MMWR™

Morbidity and Mortality Weekly Report

Weekly October 13, 2006 / Vol. 55 / No. 40

National Action Week for the Bone and Joint Decade — October 12–20, 2006

National Action Week for the Bone and Joint Decade, a global, multidisciplinary initiative promoting the care of persons with bone and joint disorders, is being observed October 12–20. This initiative focuses on improving quality of life and advancing the understanding and treatment of musculoskeletal conditions through research, prevention, and education. CDC, the National Institutes of Health, the World Health Organization, and the United Nations are among the governmental and nongovernmental organizations supporting this initiative. In 2002, the United States officially proclaimed the years 2002–2011 as the National Bone and Joint Decade.

Bone and joint disorders are the leading causes of disability in the United States (*1*) and impose substantial burdens on the health-care system and society (*2*). The United States Bone and Joint Decade organization is committed to raising awareness of the growing burden of musculoskeletal conditions and promoting their prevention, advancing research, and improving diagnosis and treatment. This week, two education programs will be inaugurated by the U.S. group: Straighten Up America and Joint Health and Arthritis. Additional information regarding the United States Bone and Joint Decade is available at http://www.usbjd.org and regarding the national action week is available at http://www.usbjd.org/rd/?naw. Information about activities worldwide is available at http://www.boneandjointdecade.org.

References

1. CDC. Prevalence of disabilities and associated health conditions among adults—United States, 1999. MMWR 2001;50:120–5.
2. Praemer A, Furner S, Rice DP. Musculoskeletal conditions in the United States. Rosemont, IL: American Academy of Orthopaedic Surgeons; 1999.

Prevalence of Doctor-Diagnosed Arthritis and Arthritis-Attributable Activity Limitation — United States, 2003–2005

Arthritis is highly prevalent among U.S. adults, the leading cause of disability (*1*), and associated with substantial activity limitation, work disability, reduced quality of life, and high health-care costs (*2–4*). As the population ages, arthritis is expected to affect an estimated 67 million adults in the United States by 2030 (*5*). This report updates estimates of the national prevalence of doctor-diagnosed arthritis and arthritis-attributable activity limitation in the adult U.S. population, using data from the National Health Interview Survey (NHIS) for 2003–2005. The findings indicated that an estimated 21.6% of the adult U.S. population (46.4 million persons) had doctor-diagnosed arthritis, and 8.3% (17.4 million) had arthritis-attributable activity limitations. Public and private health agencies should promote measures to increase the availability of evidence-based arthritis prevention and management interventions.

INSIDE

Recommended Adult Immunization Schedule — United States, October 2006–September 2007

1093 Update on Vaccine-Derived Polioviruses
1097 West Nile Virus Activity — United States, January 1–October 10, 2006
1098 Botulism Associated with Commercial Carrot Juice — Georgia and Florida, September 2006
1100 Notice to Readers
1101 QuickStats

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

Suggested Citation: Centers for Disease Control and Prevention. [Article title]. MMWR 2006;55:[inclusive page numbers].

Centers for Disease Control and Prevention

Julie L. Gerberding, MD, MPH
Director

Tanja Popovic, MD, PhD
(Acting) Chief Science Officer

James W. Stephens, PhD
(Acting) Associate Director for Science

Steven L. Solomon, MD
Director, Coordinating Center for Health Information and Service

Jay M. Bernhardt, PhD, MPH
Director, National Center for Health Marketing

Judith R. Aguilar
(Acting) Director, Division of Health Information Dissemination (Proposed)

Editorial and Production Staff

Eric E. Mast, MD, MPH
(Acting) Editor, MMWR *Series*

Suzanne M. Hewitt, MPA
Managing Editor, MMWR *Series*

Douglas W. Weatherwax
(Acting) Lead Technical Writer-Editor

Catherine H. Bricker, MS
Jude C. Rutledge
Writers-Editors

Beverly J. Holland
Lead Visual Information Specialist

Lynda G. Cupell
Malbea A. LaPete
Visual Information Specialists

Quang M. Doan, MBA
Erica R. Shaver
Information Technology Specialists

Editorial Board

William L. Roper, MD, MPH, Chapel Hill, NC, Chairman
Virginia A. Caine, MD, Indianapolis, IN
David W. Fleming, MD, Seattle, WA
William E. Halperin, MD, DrPH, MPH, Newark, NJ
Margaret A. Hamburg, MD, Washington, DC
King K. Holmes, MD, PhD, Seattle, WA
Deborah Holtzman, PhD, Atlanta, GA
John K. Iglehart, Bethesda, MD
Dennis G. Maki, MD, Madison, WI
Sue Mallonee, MPH, Oklahoma City, OK
Stanley A. Plotkin, MD, Doylestown, PA
Patricia Quinlisk, MD, MPH, Des Moines, IA
Patrick L. Remington, MD, MPH, Madison, WI
Barbara K. Rimer, DrPH, Chapel Hill, NC
John V. Rullan, MD, MPH, San Juan, PR
Anne Schuchat, MD, Atlanta, GA
Dixie E. Snider, MD, MPH, Atlanta, GA
John W. Ward, MD, Atlanta, GA

NHIS is an annual, household-based survey of a representative sample of the U.S. civilian, noninstitutionalized population, using in-person interviews. This study used the sample adult core component of the NHIS survey, which collects information on adults aged ≥18 years residing in selected households. In 2003, 2004, and 2005, the sample sizes were 30,852, 31,326, and 31,428, respectively, for the adult core component, and the final response rates were 74.2%, 72.5%, and 69.0%, respectively. Respondents were defined as having doctor-diagnosed arthritis if they answered "yes" to the question, "Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?" Those who answered "yes" were asked, "Are you limited in any way in any of your usual activities because of arthritis or joint symptoms?" Persons responding "yes" to both questions were defined as having an arthritis-attributable activity limitation.

For this study, prevalence estimates are presented overall and by sex, age group, race/ethnicity, education level, body mass index (BMI)* category, and physical activity level. Physical activity level of respondents was determined from six questions that asked about frequency and duration of participation in leisure-time activities of moderate and vigorous intensity; those reporting no participation in such activities were classified as inactive, and all others as active. Estimates were calculated by using combined data from 2003–2005 and applying an annual average weighting; 95% confidence intervals (CIs) were calculated using sample design factors and statistical software to account for the multistage probability sample. To facilitate comparisons between demographic subgroups, estimates were age adjusted to the standard 2000 U.S. population (*6*). All differences noted in this report are statistically significant ($p<0.05$) with nonoverlapping 95% CIs.

In unadjusted analyses for 2003–2005 (Table), the prevalence of doctor-diagnosed arthritis among adults was estimated at 21.6%, or 46.4 million persons. Prevalence was higher among women (25.4%) compared with men (17.6%), older age groups (50% for persons aged ≥65 years and 29.3% for persons aged 45–64 years) compared with younger age groups (7.9% for persons aged 18–44 years), and non-Hispanic whites (24.3%) compared with non-Hispanic blacks (19.2%) and Hispanics (11.4%). Prevalence also was higher among those who were obese (31.6%) or overweight (21.7%) compared with those who were normal weight or underweight (16.3%)

* BMI was calculated using self-reported weight and height as follows: weight (kg) / height (m^2). Categories were defined as follows: underweight/normal weight, ≤24.9; overweight, 25.0–29.9; and obese, ≥30.0.

TABLE. Unadjusted and age-adjusted* estimates of the prevalence of doctor-diagnosed arthritis and arthritis-attributable activity limitations† among adults aged ≥18 years, by selected characteristics — National Health Interview Survey, United States, 2003–2005

Characteristic	Adult population prevalence: Doctor-diagnosed arthritis (46.4 million persons)		Adult population prevalence: Arthritis-attributable activity limitation (17.4 million persons)		Proportion with arthritis-attributable activity limitation among those with doctor-diagnosed arthritis	
	Unadjusted % (95% CI§)	Age adjusted % (95% CI)	Unadjusted % (95% CI)	Age adjusted % (95% CI)	Unadjusted % (95% CI)	Age adjusted % (95% CI)
Sex						
Men	17.6 (±0.5)	18.1 (±0.5)	6.4 (±0.3)	6.6 (±0.4)	36.6 (±1.4)	35.2 (±1.6)
Women	25.4 (±0.6)	24.4 (±0.5)	10.0 (±0.3)	9.7 (±0.3)	40.1 (±1.0)	37.5 (±1.3)
Age (yrs)						
18–44	7.9 (±0.3)	—	2.7 (±0.2)	—	33.9 (±1.8)	—
45–64	29.3 (±0.7)	—	11.3 (±0.5)	—	38.6 (±1.4)	—
≥65	50.0 (±0.9)	—	20.5 (±0.7)	—	41.5 (±1.3)	—
Race/Ethnicity						
White, non-Hispanic	24.3 (±0.5)	22.6 (±0.4)	8.9 (±0.3)	8.4 (±0.3)	37.4 (±0.9)	35.0 (±1.2)
Black, non-Hispanic	19.2 (±0.9)	21.4 (±0.9)	8.8 (±0.6)	10.0 (±0.6)	45.7 (±2.4)	43.4 (±3.1)
Hispanic	11.4 (±0.6)	16.5 (±0.8)	5.0 (±0.4)	7.3 (±0.6)	43.8 (±2.7)	42.3 (±3.2)
Other non-Hispanic	14.7 (±1.3)	17.3 (±0.5)	5.7 (±0.8)	7.0 (±1.0)	41.5 (±4.6)	40.0 (±5.3)
Education						
Did not graduate from high school	27.0 (±1.0)	23.2 (±0.8)	13.6 (±0.6)	11.7 (±0.6)	50.6 (±1.6)	49.3 (±3.0)
High school graduate or more	20.8 (±0.4)	21.2 (±0.4)	7.4 (±0.2)	7.7 (±0.2)	36.1 (±0.9)	34.5 (±1.1)
Body mass index (BMI¶)						
Underweight/Normal weight	16.3 (±0.5)	17.4 (±0.5)	5.5 (±0.3)	5.9 (±0.3)	34.3 (±1.4)	32.4 (±1.8)
Overweight	21.7 (±0.6)	20.5 (±0.5)	7.5 (±0.3)	7.1 (±0.3)	35.0 (±1.3)	33.4 (±1.8)
Obese	31.6 (±0.8)	29.3 (±0.7)	14.4 (±0.6)	13.8 (±0.6)	46.4 (±1.6)	43.2 (±1.9)
Physical activity level						
Inactive	25.0 (±0.6)	22.3 (±0.5)	13.2 (±0.5)	11.7 (±0.4)	52.6 (±1.3)	49.8 (±2.1)
Active	19.5 (±0.5)	20.8 (±0.5)	6.1 (±0.3)	6.6 (±0.3)	31.3 (±1.0)	29.9 (±1.2)
Total	**21.6 (±0.4)**	**21.5 (±0.4)**	**8.3 (±0.2)**	**8.3 (±0.2)**	**38.8 (±0.8)**	**36.6 (±1.0)**

* Adjusted to the projected 2000 population aged ≥18 years by three age groups: 18–44 years, 45–64 years, and ≥65 years.
† Doctor-diagnosed arthritis was defined as those answering "yes" to the question, "Have you ever been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?" Those who answered "yes" were asked, "Are you limited in any way in any of your usual activities because of arthritis or joint symptoms?" Persons responding "yes" to both questions were defined as having an arthritis-attributable activity limitation.
§ Confidence interval.
¶ BMI = weight (kg) / height (m^2). Underweight/normal weight, ≤24.9; overweight, 25.0–29.9; and obese, ≥30.0.

and among those who were physically inactive (25.0%) compared with those who were physically active (19.5%). After adjustment for age, all of these differences (except among age groups) were slightly attenuated but remained significant, with the exception of differences between non-Hispanics whites (22.6%) and non-Hispanic blacks (21.4%).

Unadjusted analyses for arthritis-attributable activity limitation among adults indicated an estimated overall prevalence of 8.3%, or 17.4 million persons, with differences among groups that were similar to those for doctor-diagnosed arthritis prevalence. The exception was a similar prevalence for non-Hispanic blacks (8.8%) and non-Hispanic whites (8.9%). Age-adjusted analyses identified differences among groups that were similar to the unadjusted figures, except that prevalence among non-Hispanic blacks (10.0%) significantly exceeded that for non-Hispanic whites (8.4%).

In unadjusted analyses of all adults reporting arthritis, 38.8% reported arthritis-attributable activity limitation (Table). Proportions were significantly higher among women (40.1%) compared with men (36.6%) and among non-Hispanic blacks (45.7%) and Hispanics (43.8%) compared with non-Hispanic whites (37.4%). Persons with arthritis and activity limitations also were more likely to have less than a high school education (50.6% versus 36.1%) or to be obese (46.4% versus 34.3% underweight/normal weight) or physically inactive (52.6% versus 31.3%). Age-adjusted analyses eliminated the significant difference between men and women, but did not otherwise change the results.

Reported by: *J Hootman, PhD, J Bolen, PhD, C Helmick, MD, G Langmaid, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings in this report indicate that 21.6% (46.4 million) of U.S. adults reported doctor-diagnosed arthritis, and 8.3% (17.4 million) reported arthritis-attributable activity limitation during 2003–2005. This represents an increase from 2002, when an estimated 20.8% (42.7 million) reported doctor-diagnosed arthritis and 7.8% (16.0 million) reported arthritis-attributable activity limitation (*2*). The increase in both the prevalence of doctor-diagnosed arthritis and arthritis-attributable activity limitation is consistent with future projections, largely based on the aging of the population (*5*). However, in 2003, the NHIS transitioned to a weighting structure based on the 2000 U.S. Census population; therefore, interpretation of this increased prevalence should be made with caution. Additional years of data are needed to determine whether these growth trends will be lasting.

Disparities exist with regard to arthritis and activity limitations. Women, older adults, persons with little education, or those who are obese, overweight, or physically inactive are more likely affected. In unadjusted analyses, doctor-diagnosed arthritis was less prevalent among non-Hispanic blacks and Hispanics than among non-Hisipanic whites; however, both groups reported greater proportions of persons with arthritis-attributable activity limitation.

In contrast to previous estimates of arthritis prevalence based on 1 year of data, prevalences for a 3-year period were used to reduce the year-to-year fluctuation that can result from smaller sample sizes from a single year. This approach might provide more reliable estimates, especially for smaller groups such as certain racial/ethnic populations and older adults.

The findings in this report are subject to at least three limitations. First, doctor-diagnosed arthritis was self-reported and not confirmed by a health-care professional, although self-report of arthritis has been determined valid for surveillance purposes (*7*). Second, the cross-sectional study design does permit determining the temporal sequence of arthritis onset and selected characteristics (e.g., obesity or physical inactivity). However, other studies have identified excess body weight as a risk factor for incident osteoarthritis, the most common type of arthritis, and physical activity has been determined to prevent or delay onset of functional limitation and disability among adults with osteoarthritis (*8*). Finally, certain factors that might contribute to differences in arthritis prevalence (e.g., history of joint injury or comorbid conditions such as cardiovascular disease, diabetes, or depression) were not analyzed.

Population-based national surveillance of arthritis prevalence and associated effects such as arthritis-attributable activity limitation are important to identify groups at greatest risk, target interventions, and measure progress toward achieving national health objectives (*9*). Currently, the CDC Arthritis Program is focusing on expanding the availability of evidence-based physical-activity and self-management interventions proven to reduce pain and improve function among adults with arthritis. Such interventions include those related to safe physical activity for persons with arthritis (e.g., Arthritis Foundation's Exercise Program, Arthritis Foundation's Aquatics Program, and EnhanceFitness) and self-management education (e.g., Arthritis Foundation's Self-Help Course and the Chronic Disease Self-Management Program). In addition, the CDC Arthritis Program is working with 35 state health department programs and various local chapters of the Arthritis Foundation to disseminate a health communications campaign designed to promote greater physical activity among adults with arthritis. The campaign, "Physical Activity. The Arthritis Pain Reliever," was developed to target an audience of low-income men and women aged ≥45 years with arthritis. A similar campaign targeted to Spanish-speaking adults, "Buenos Dias Artritis," is being developed and tested.† Further research is needed to investigate possible underlying reasons for the differences among groups in arthritis prevalence and activity limitation and to develop more targeted solutions to improve the quality of life for all adults with arthritis, particularly among those most affected.

References

1. CDC. Prevalence of disabilities and associated health conditions among adults—United States, 1999. MMWR 2001;50:120–5.
2. CDC. Racial/ethnic differences in the prevalence and impact of doctor-diagnosed arthritis—United States, 2002. MMWR 2005;54:119–23.
3. Mili F, Helmick CG, Moriarty DG. Health related quality of life among adults reporting arthritis: analysis of data from the Behavioral Risk Factor Surveillance System, U.S., 1996–99. J Rheumatol 2003;30:160–6.
4. CDC. Targeting arthritis: reducing disability for 43 million Americans: at a glance 2006. Atlanta, GA: US Department of Health and Human Services, CDC; 2006. Available at www.cdc.gov/nccdphp/aag/aag_arthritis.htm.
5. Hootman JM, Helmick CG. Projections of US prevalence of arthritis and associated activity limitations. Arthritis Rheum 2006;54:226–9.
6. Klein RJ, Schoenborn CA. Healthy people 2010: age adjustment using the 2000 projected U.S. population. Hyattsville, MD: US Department of Health and Human Services, CDC; 2001. Available at http://www.cdc.gov/nchs/data/statnt/statnt20.pdf.
7. Sacks JJ, Harrold LR, Helmick CG, Gurwitz JH, Emani S, Yood RA. Validation of a surveillance case definition for arthritis. J Rheumatol 2005;32:340–7.
8. Felson DT. Relation of obesity and of vocational and avocational risk factors to osteoarthritis. J Rheumatol 2005;32:1133–5.
9. US Department of Health and Human Services. Healthy people 2010 (conference ed, in 2 vols). Washington, DC: US Department of Health and Human Services; 2000. Available at http://www.health.gov/healthypeople.

†Additional information on arthritis programs is available at http://www.cdc.gov/arthritis.

Update on Vaccine-Derived Polioviruses

In 1988, the World Health Assembly resolved to eradicate polio worldwide. The Global Polio Eradication Initiative (PEI) of the World Health Organization (WHO) has led to a decline in global polio incidence, from an estimated 350,000 cases in 1988 to fewer than 2,000 reported cases in 2005, and polio remains endemic to only four countries (Afghanistan, India, Nigeria, and Pakistan) (*1*). However, two additional obstacles to global eradication involve vaccine-derived polioviruses (VDPVs). Polio outbreaks continue to be associated with circulating vaccine-derived polioviruses (cVDPVs) in areas with low oral poliovirus vaccine (OPV) coverage. In addition, long-term excretion of neurovirulent immunodeficiency-associated vaccine-derived polioviruses (iVDPVs) can lead to poliovirus spread to contacts. Overcoming these obstacles is challenging. High rates of OPV coverage will prevent all poliovirus spread, including spread of VDPVs, but will not prevent establishment of prolonged VDPV infections in certain persons with B-cell immunodeficiencies (i.e., having defects in antibody production). Inevitable gaps in vaccination coverage will give rise to cVDPVs as long as OPV use continues. This report updates a previous report on VDPVs and describes the potential implications of VDPVs in the final stages of global polio eradication (*2*). The findings underscore the critical need to strengthen strategies to prevent emergence of VDPVs and to stop all OPV use once wild polioviruses (WPVs) are eradicated (*2–5*).

Biologic Properties of VDPVs

The critical biologic properties of VDPVs are their capacity to cause paralytic polio in humans and their potential or demonstrated capacity for sustained circulation. VDPVs have lost key attenuating mutations and resemble WPVs biologically (*2*). All known cVDPVs (except those from China) (Table 1), but no iVDPVs, are recombinants with nonstructural protein sequences derived from species C enteroviruses, a property associated with poliovirus circulation (*2*). Most VDPVs are antigenic variants of the Sabin strains, but antigenic evolution appears to be faster in iVDPVs than in cVDPVs. Unlike cVDPV isolates, iVDPV isolates commonly contain mixed VDPV populations. These biologic distinctions (and the differing conditions favoring iVDPV and cVDPV emergence) have helped in recognition of the likely origins of many ambiguous VDPVs (aVDPVs) (*2*).

Categories of VDPVs

VDPVs differ from the majority of vaccine-related isolates by having genetic properties consistent with prolonged replication or transmission. Because poliovirus genomes evolve at a rate of approximately 1% per year, vaccine-related isolates

TABLE 1. Outbreaks of circulating vaccine-derived polioviruses (cVDPVs) — worldwide, 1988–2006

Location	Years	Reported no. of polio cases	Serotype	No. of clinical isolates (% VP1 divergence from Sabin strain)	Recombination with species C enteroviruses*	Estimated duration of circulation	Routine vaccination coverage with 3 doses of oral polio vaccine (OPV)
Egypt†	1988–1993	30	2	30 (4.0–7.0)	Yes	10.0 yrs	Reported high
Haiti§	2000–2001	8	1	8 (1.9–2.6)	Yes	2.5 yrs	<30% nationwide
Dominican Republic§	2000–2001	13	1	13 (1.9–2.6)	Yes	>0.5 yr	<30% around most cases
Philippines	2001	3	1	4 (3.1–3.5)	Yes	2.5 yrs	OPV shortage previous 2 yrs
Madagascar¶**	2002	4	2	6 (2.5–3.0)	Yes	2.5 yrs	<50% nationwide
China†† §§	2004	2	1	4 (1.0–1.2)	No	1.0 yr	<50% around cases
Madagascar§§	2005	3	2	3 (1.1–1.8)	Yes	1.0 yr	<50% nationwide
Indonesia§§ ¶¶	2005	46	1	46 (1.1–3.0)	Yes	2.0 yrs	<40% in Madura
Cambodia§§	2005–2006	3	3	3 (1.9–2.4)	Yes	>1.0 yr	<50% around cases

* All cVDPV isolates except those from China were vaccine/nonvaccine recombinants.
† Inferred retrospectively from sequence studies of stored isolates. Not investigated in the field.
§ Common outbreak. In 2000, cVDPV spread from Haiti to the Dominican Republic.
¶ In 2001, an unrelated type 2 ambiguous VDPV isolate (1% VP1 divergence) was obtained from a patient with acute flaccid paralysis in a separate community in Madagascar.
** VDPVs were isolated from four polio patients (March–April 2002) and from two healthy children (from a stool survey of 316 healthy children conducted in June 2002 in the outbreak area).
†† Localized outbreak in Guizhou province.
§§ New cases reported since publication of previous report (*2*).
¶¶ Localized outbreak on Madura Island off coast of Java.

that differ from the corresponding OPV strain by more than 1% of nucleotide positions (usually determined by sequencing the genomic region encoding the major viral surface protein, VP1) are estimated to have replicated for at least 1 year after administration of an OPV dose, substantially longer than the normal period of vaccine virus replication of 4–6 weeks. Poliovirus isolates are divided into three categories, identified by the extent of VP1 nucleotide sequence divergence from the corresponding Sabin OPV strain: 1) OPV-like viruses (<1% divergent), 2) VDPVs (1%–15% divergent), and 3) WPVs (>15% divergent) (*2*). VDPVs are further divided into 1) iVDPVs isolated from persons with primary immunodeficiencies who have prolonged VDPV infections after exposure to OPV, 2) cVDPVs that emerge in communities with inadequate OPV coverage, and 3) aVDPVs, which are clinical isolates from persons with no known immunodeficiency and environmental isolates whose ultimate source has not been identified (*2*).

iVDPVs

A small proportion of immunodeficient persons exposed to OPV have excreted iVDPV over prolonged periods (>6 months). WHO maintains an iVDPV registry; since the introduction of OPV in 1961–1962, only 30 persons excreting iVDPVs have been identified. Persons with primary B-cell immunodeficiencies, but not persons with T-cell immunodeficiencies (e.g., from human immunodeficiency virus infection), are at risk for iVDPV infections (*6*). Approximately 70% of iVDPV infections have spontaneously ceased within 3 years of exposure to OPV, or the patients have died from complications of their immunodeficiency. Five persons excreted virus for 3–8 years, and in three persons, the duration of excretion exceeded 9 years (Table 2). Eighteen (60%) documented iVDPV infections were associated with type 2 poliovirus infection, eight (27%) with type 1, one (3%) with type 3, and three (9%) with mixed infections (Table 2, Figure). The first reports of iVDPVs came from high-income countries (e.g., the United States, countries of Western Europe, and Japan) but recent reports of iVDPVs include middle-income countries (Table 2). No iVDPVs have been reported from low-income countries, where survival rates for persons with B-cell immunodeficiencies are low (*7*). Exposure usually is from receipt of OPV, but three of the known iVDPV infections occurred in unimmunized persons (Table 2). Strategies for resolving iVDPV infections are needed, both because of the risk for paralytic disease to infected persons and the risk for transmission to the wider community. No antiviral drug that has been shown to resolve iVDPV infections is currently available. However, new antiviral drugs broadly effective against VDPVs are under development (*8*).

cVDPVs

VDPVs do not circulate when high vaccination coverage leads to high population immunity. However, low vaccination coverage increases the proportion of nonimmune persons in a population; this increases the potential for VDPVs to circulate. Under circumstances of low vaccination coverage, cVDPVs have produced several localized polio outbreaks. Eight independent outbreaks (i.e., two or more polio cases) in eight countries have been associated with cVDPVs (Table 1, Figure). The largest documented outbreak (46 polio cases) occurred on the Indonesian island of Madura. Genetic studies on stored isolates suggest that a type 2 cVDPV circulated endemically in Egypt for 10 years (approximately from 1983 to 1993) and probably caused more polio cases than were reported (*2*). Outbreaks of cVDPVs have been associated with all three poliovirus serotypes. Two independent type 2 cVDPV outbreaks occurred in Madagascar in 2002 and 2005 (*2*), possibly signaling a higher potential for the emergence of type 2 cVDPVs.

aVDPVs

aVDPVs are VDPV isolates that cannot be clearly assigned to either of the other two well-defined categories. They have been isolated from paralyzed persons with no evidence of additional paralyzed VDPV-infected persons among household or community contacts. Highly divergent (>12% VP1 nucleotide divergence) aVDPVs also have been isolated from sewage in Estonia, Israel, and Slovakia. The sewage isolates have similar genetic and antigenic properties as iVDPVs, but measures to identify the infected persons have been unsuccessful. In 1966, aVDPVs were found in Belarus after local suspension of OPV use; in 1999, they were found in Russia among children in orphanages (*2*). A growing number of aVDPVs having VP1 sequence divergence slightly above 1% have been found by the Global Polio Laboratory Network.

Limited person-to-person transmission for certain aVDPVs has occurred. In 2005, a type 3 aVDPV was isolated from one polio patient and seven nonparalyzed contacts in Madagascar. Similarly, a type 1 VDPV was isolated from one patient and seven contacts in Romania in 2002, a type 2 VDPV was isolated from one patient and two contacts in Laos in 2004 (*2*), a type 1 VDPV was isolated from an unimmunized severe combined immunodeficiency (SCID) patient and four community members in rural Minnesota in 2005 (*9*), and a type 1 VDPV was isolated from one patient and six contacts in Myanmar in 2006. Other aVDPVs with genetic properties resembling those of cVDPVs were found in Peru in 1983, in Pakistan in 2000, and in Nigeria in 2002 and 2006 (*2*).

TABLE 2. Selected characteristics of persons excreting immunodeficiency-associated vaccine-derived polioviruses (iVDPVs) — worldwide, 1962–2006

Location	Year detected	Immunodeficiency	Paralysis	Serotype	Maximum % VP1 divergence from Sabin strain	Estimated interval between last oral polio vaccine (OPV) dose and detection of iVDPV infection (yrs)*	Outcome	Estimated duration of virus excretion (yrs)
United Kingdom	1962	Hypogammaglobulinemia	No	1	Unknown	0†	Died	2.7
United Kingdom	1962	Hypogammaglobulinemia	No	3	2.3	0†	Died	1.8
Japan	1977	X-linked agammaglobulinemia	Yes	2	Unknown	1.5	Died	3.4
United States	1980	Agammaglobulinemia	Yes	2	Unknown	1	Died	1§
United States	1981	Common variable immunodeficiency	Yes	1	10.0	7.1	Died	7.6
United States	1986	X-linked agammaglobulinemia	Yes	2	2.0	0.4	Survived	0.4
United States¶	1986	Common variable immunodeficiency	Yes	1	5.4	4.7	Survived	9.6
	1992	—	—	2	11.8	—	—	—
United Kingdom	1987	Common variable immunodeficiency	No	2	4.1	4	Survived	3.6
United States	1989	Agammaglobulinemia	Yes	1	1.1	0.3	NA**	Unknown
Germany	1990	Common variable immunodeficiency	Yes	1	8.3	4	Survived	9.5
United States	1990	Severe combined immunodeficiency	Yes	2	1.9	0.5	Died	0.8
United States	1991	Common variable immunodeficiency	Yes	2	1.4	0.4	Survived	0.6
Iran	1995	Antibody deficiency	Yes	2	2.2	Unimmunized	Died	1.5
United Kingdom	1995	Common variable immunodeficiency	No	2	12.9	15.7	Survived	20
United States	1995	Severe combined immunodeficiency	Yes	2	2.1	0.3	Died	3.7
Argentina	1998	X-linked agammaglobulinemia	Yes	1	2.8	Unimmunized	Survived	2
Germany	2000	Antibody deficiency	Yes	1	3.5	NA	Survived	1.5
Taiwan	2001	Common variable immunodeficiency	Yes	1	3.5	1.6	Survived	3
United Kingdom	2002	Common variable immunodeficiency	No	2	3.3	NA	Survived	3.3
United Kingdom	2002	Immunodeficiency-centromeric instability-facial abnormalities syndrome	No	2	2.5	NA	Survived	2.5
Kazakhstan	2002	Hypogammaglobulinemia	Yes	2	2.3	NA	Died	2
Kuwait	2002	Major histocompatibility complex class II molecule deficiency	No	2	2.0	0.9	Died	0.4
Peru	2003	Agammaglobulinemia	Yes	2	1.2	0.6	Survived	<1.0
Thailand	2003	Hypogammaglobulinemia	Yes	2	2.2	0.3	NA	<0.5
China††	2005	X-linked agammaglobulinemia	Yes	2+3	2.7	0.6	NA	NA
Iran††	2005	Common variable immunodeficiency	Yes	2	1.4	0.7	Died	0.7
Morocco††	2005	Severe combined immunodeficiency	Yes	2	2.5	1	Died	1
Syria††	2005	Hypogammaglobulinemia	Yes	2	1.3	<0.1	Survived	<0.1
United States††	2005	Severe combined immunodeficiency	No	1	2.3	Unimmunized	Survived	<0.5§§
Tunisia††	2006	Severe combined immunodeficiency	No	2	2.0	NA	Survived	0.1

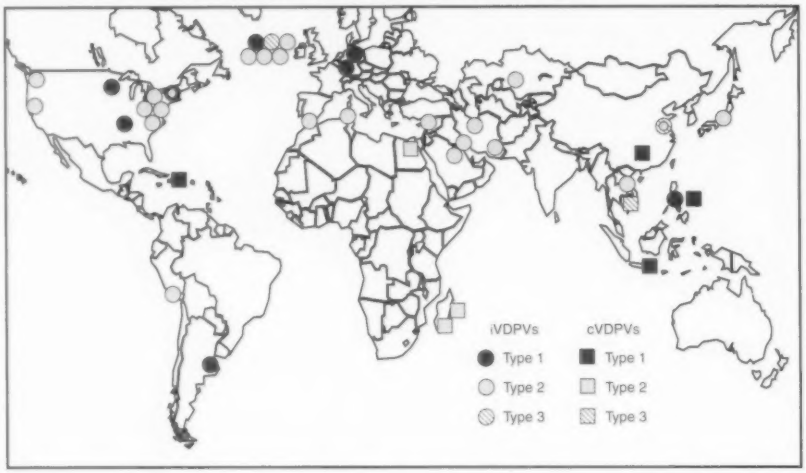
* Several estimates are approximate because of no follow-up sampling, long sampling intervals, or uncertain date of associated OPV exposure. Because criteria for estimates varied in different studies, certain estimates were rounded off to the nearest integer.
† Immunodeficient children were administered OPV, and virus excretion was monitored.
§ Neural isolate obtained at autopsy, approximately 4.3 years after last OPV dose.
¶ Two different iVDPVs were isolated from the same patient (a type 1 in 1986 and a type 2 in 1992).
** Information not available.
†† New cases reported since publication of previous report (*2*).
§§ Excretion stopped after bone marrow transplant.

Risk Factors for VDPV Emergence

The key factors favoring cVDPV emergence and spread are the same as for WPV circulation: low OPV coverage, poor sanitation, high population densities, and (usually) tropical conditions. In all but the remaining polio-endemic areas, immunity to polio is no longer acquired from natural infection; immunization is the only current means to prevent the spread of emerging VDPVs or imported WPVs (*3*).

Although OPV is not recommended for immunodeficient patients, it is often inadvertently administered because certain primary immunodeficiencies (e.g., common variable immunodeficiency [CVID]) develop later in life. Certain persons with CVID who excrete iVDPVs had onset of polio several years after the implicated OPV dose was administered, and three have demonstrated no signs of paralysis. Survival of patients with primary immunodeficiencies can be extended

FIGURE. Locations of persons excreting immunodeficiency-associated vaccine-derived polioviruses (iVDPVs), 1962–2006, and polio outbreaks associated with circulating vaccine-derived polioviruses (cVDPVs), 1988–2006



in upper- and middle-income countries by intravenous immunoglobulin therapy; however, for patients in low-income countries, such therapy often is too expensive and difficult to obtain (*7*).

Global VDPV Surveillance

Since the cVDPV outbreak in Haiti and the Dominican Republic in 2000–2001 (Figure, Table 1), all polioviruses isolated in the WHO Global Poliovirus Laboratory Network from patients with acute flaccid paralysis have been characterized by one molecular method, to identify polioviruses by their genetic properties (usually using the polymerase chain reaction), and one antigenic method, to detect antigenic differences from the OPV strains (using either an enzyme-linked immunosorbent assay [ELISA] or panels of specific neutralizing monoclonal antibodies) (*10*). Isolates found to be genetically related to an OPV strain but with antigenic differences are possible VDPVs. VP1 sequencing is routinely performed on all possible VDPV and WPV isolates. Approximately 12,000 isolates from all WHO regions have been routinely screened for VDPVs since 2001 (*10*). Temporal or geographic clustering of vaccine-related isolates of the same serotype has prompted the detection and investigation of cVDPV outbreaks in eight countries (Table 1).

Reported by: *WHO Global Poliovirus Laboratory Network. Immunization, Vaccines and Biologicals Dept, WHO, Geneva, Switzerland. Div of Viral Diseases and Global Immunization Div, National Center for Immunization and Respiratory Diseases (proposed), CDC.*

Editorial Note: VDPVs will continue to emerge as long as OPV is used. Intensified surveillance has indicated that cVDPVs can emerge repeatedly under conditions of low OPV coverage (e.g., Madagascar). VDPVs also can be found in developed countries with no paralytic cases (e.g., Estonia, Israel, and Slovakia) and can circulate in isolated pockets of unimmunized persons in countries with overall high rates of vaccination coverage (e.g., China and the United States). Although iVDPVs can emerge in middle-income developing countries, cVDPVs have not been found in some areas of high biologic risk, such as in northern India, presumably because of the current high rates of OPV coverage.

Occurrences of VDPVs, including cVDPV-related outbreaks, are rare events, and all recent outbreaks of cVDPVs have been rapidly interrupted using OPV campaigns. The recent increase in the detection of VDPVs is probably primarily attributable to intensified surveillance and improved laboratory methods. Enhanced surveillance for VDPVs has allowed for better understanding of the risks associated with the different types of VDPVs. Areas with continued use of OPV but lacking optimal coverage (e.g., Indonesia in 2005) are at increased risk for cVDPV emergence. The importance of detecting aVDPVs with limited VP1 divergence is not clear; the presence of aVDPVs in certain settings might not have any public health consequences, whereas aVDPVs found elsewhere might signal conditions favoring the emergence of a cVDPV.

Under certain circumstances, OPV viruses regain both neurovirulence and the capacity to circulate and cause outbreaks and therefore are of concern to the PEI. After global eradication of WPVs, the continued use of OPV would continually generate cVDPVs and could eventually pose a challenge to the goal of stopping all poliovirus infections in the human population. The increasing risk of cVDPV emergence in countries with widening immunity gaps and the ongoing risks for vaccine-associated paralytic polio and iVDPVs have prompted an evaluation of the feasibility of orderly cessation of OPV use as soon as possible in the posteradication era (*4*) while population immunity and surveillance sensitivity are still high (*6*). Continued development and implementation of a comprehensive strategy to minimize the risks for VDPV emergence in the posteradication era presents a challenge to the PEI and to the public health and scientific communities.

References

1. CDC. Progress toward interruption of wild poliovirus transmission—worldwide, January 2005–March 2006. MMWR 2006;55:458–62.
2. Kew OM, Sutter RW, de Gourville EM, Dowdle WR, Pallansch MA. Vaccine-derived polioviruses and the endgame strategy for global polio eradication. Annu Rev Microbiol 2005;59:587–635.
3. Duintjer Tebbens RJ, Pallansch MA, Kew OM, et al. Risks of paralytic disease due to wild or vaccine-derived poliovirus after eradication. Risk Analysis. In press 2006.
4. World Health Organization. Progress towards global poliomyelitis eradication: preparation for the oral poliovirus vaccine cessation era. Wkly Epidemiol Rec 2004;79:349–55.
5. World Health Organization. Conclusions and recommendations of the Advisory Committee on Poliomyelitis Eradication, Geneva, 11–12 October 2005. Wkly Epidemiol Rec 2005;80:410–6.
6. Hennessey KA, Lago H, Diomande F, et al. Poliovirus vaccine shedding among persons with HIV in Abidjan, Cote d'Ivoire. J Infect Dis 2005;192:2124–8.
7. Halsey NA, Pinto J, Espinosa-Rosales F, et al. Search for poliovirus carriers in persons with primary immune deficiency diseases in the United States, Mexico, Brazil, and the United Kingdom. Bull WHO 2004;82:3–8.
8. National Research Council. Workshop report: exploring the role of antiviral drugs in the eradication of polio. Washington, DC: National Academies Press; 2006.
9. CDC. Imported vaccine-associated paralytic poliomyelitis—United States, 2005. MMWR 2006;55:97–9.
10. CDC. Laboratory surveillance for wild and vaccine-derived polioviruses, January 2004–June 2005. MMWR 2005;54:958–61.

West Nile Virus Activity — United States, January 1–October 10, 2006

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m. Mountain Daylight Time, October 10, 2006. A total of 41 states and the District of Columbia had reported 3,135 cases of human WNV illness to CDC (Table, Figure). A total of 1,717 (55%) cases for which such data were available occurred in males; median age of patients was 50 years (range: 3 months–99 years). Dates of illness onset ranged from January 6 to September 25; a total of 97 cases were fatal.

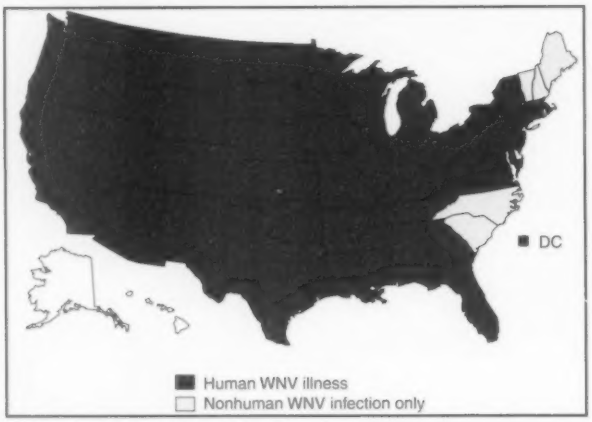
A total of 260 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2006. Of these, 40 were reported from Nebraska; 27 from Texas; 24 from Utah; 21 from Colorado; 15 from California; 14 from Louisiana; 11 each from North Dakota and South Dakota; 10 each from Iowa and Wisconsin; nine each from Arizona, Mississippi, and Oklahoma; eight from Kansas; six from Idaho; five each from Minnesota and Virginia; four each from Kentucky and Missouri; three each from Illinois, Montana, and Nevada; two from Michigan; and one each from Arkansas, Maryland, New York, Ohio, Oregon, Pennsylvania, and Wyoming. Of the 260 PVDs, three persons (median age: 73 years [range: 26–74 years]) subsequently had neuroinvasive illness, one person aged 41 years had other illness, and 54 persons (median age: 46 years [range: 17–70 years]) had West Nile fever.

TABLE. Number of human cases of West Nile virus (WNV) illness, by state — United States, 2006*

State	Neuroinvasive disease†	West Nile fever§	Other clinical/ unspecified¶	Total reported to CDC**	Deaths
Alabama	4	0	1	**5**	0
Arizona	15	14	16	**45**	3
Arkansas	21	5	0	**26**	0
California	65	164	13	**242**	3
Colorado	54	219	0	**273**	3
Connecticut	6	2	0	**8**	1
District of Columbia	0	1	0	**1**	0
Florida	3	0	0	**3**	0
Georgia	2	4	1	**7**	1
Idaho	94	542	6	**642**	10
Illinois	111	55	23	**189**	9
Indiana	11	5	12	**28**	0
Iowa	17	12	0	**29**	0
Kansas	14	10	0	**24**	3
Kentucky	5	1	0	**6**	1
Louisiana	66	49	0	**115**	0
Maryland	2	1	1	**4**	0
Massachusetts	2	1	0	**3**	0
Michigan	29	2	6	**37**	3
Minnesota	29	34	0	**63**	3
Mississippi	72	79	0	**151**	6
Missouri	41	9	1	**51**	2
Montana	10	19	1	**30**	0
Nebraska	33	123	0	**156**	1
Nevada	34	73	14	**121**	1
New Jersey	2	2	1	**5**	0
New Mexico	1	2	0	**3**	0
New York	7	3	1	**11**	2
North Dakota	20	115	0	**135**	1
Ohio	27	7	0	**34**	3
Oklahoma	21	12	1	**34**	5
Oregon	4	42	8	**54**	0
Pennsylvania	7	1	0	**8**	2
South Dakota	37	71	0	**108**	3
Tennessee	7	1	0	**8**	1
Texas	175	81	0	**256**	23
Utah	48	88	0	**136**	4
Virginia	0	0	2	**2**	0
Washington	0	2	0	**2**	0
West Virginia	1	0	0	**1**	0
Wisconsin	10	8	0	**18**	1
Wyoming	14	36	11	**61**	2
Total	**1,121**	**1,895**	**119**	**3,135**	**97**

* As of October 10, 2006.
† Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).
§ Cases with no evidence of neuroinvasion.
¶ Illnesses for which sufficient clinical information was not provided.
** Total number of human cases of WNV illness reported to ArboNET by state and local health departments.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2006*



* As of October 10, 2006.

In addition, 2,746 dead corvids and 636 other dead birds with WNV infection have been reported in 41 states and New York City during 2006. WNV infections have been reported in horses in 34 states, in one squirrel in Kansas, and in two unidentified animal species in North Carolina and Wyoming. WNV seroconversions have been reported in 682 sentinel chicken flocks in 12 states (Arizona, Arkansas, California, Florida, Iowa, Montana, Nevada, North Carolina, North Dakota, Pennsylvania, Utah, and Virginia). A total of 10,157 WNV-positive mosquito pools have been reported from 38 states, the District of Columbia, and New York City.

Additional information about national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

Botulism Associated with Commercial Carrot Juice — Georgia and Florida, September 2006

On October 6, this report was posted as an MMWR *Dispatch on the* MMWR *website* (http://www.cdc.gov/mmwr).

On September 8, 2006, the Georgia Division of Public Health (GDPH) and CDC were notified of three suspected cases of foodborne botulism in Washington County, Georgia. On September 25, the Florida Department of Health and CDC were notified of an additional suspected case in Tampa, Florida. This report describes the joint investigation and control measures undertaken by state and local health departments, CDC, and the Food and Drug Administration (FDA).

On September 8, the three patients from Washington County, Georgia, went to a local hospital with cranial nerve palsies and progressive descending flaccid paralysis resulting in respiratory failure; the patients had shared meals on September 7. On the evening of September 8, physicians suspected foodborne botulism, notified the state health department, and collected clinical specimens for testing at CDC. On the same evening, CDC provided clinical consultation and dispatched botulinum antitoxin, which was administered to each of the patients the following morning. After receiving antitoxin, the patients had no progression of neurologic symptoms, but they remain hospitalized and on ventilators.

On September 9, the Washington County Health Department, Richmond County Health Department, and GDPH launched an investigation. The three patients had consumed several food items during their two meals together on September 7, including juice from a single 1-liter bottle of Bolthouse Farms carrot juice. The bottle had a "best if used by" date of September 18, 2006. Clinical specimens and leftover food and juice were collected and sent to CDC for testing. On September 13, botulinum toxin type A was identified in the serum and stool of all three patients. On September 15, leftover carrot juice recovered from the home of one of the patients also tested positive for botulinum toxin type A.

During September 8–15, FDA, the Georgia Department of Agriculture, the Georgia Hospital Association, and public health officials in all 50 states were notified of the outbreak and the implicated product as information became available. After these notifications, no additional cases of botulism in Georgia were reported to the state and local health departments or to CDC. During this time, FDA launched an investigation of the Bolthouse Farms, Inc., manufacturing plant in Bakersfield, California. FDA and CDC tested other bottles of the implicated brand of carrot juice, including bottles from different lots, and all were negative for botulinum toxin. Because botulinum toxin was found only in the bottle of carrot juice consumed by the three patients, a lapse in refrigeration of the carrot-juice bottle during transport or storage was suspected, which would have allowed for growth of *Clostridium botulinum* and subsequent production of botulinum toxin. Based on the CDC test results, on September 17, FDA issued a consumer advisory on the importance of keeping carrot juice refrigerated. However, information obtained from patient interviews regarding storage and transport of the carrot juice did not confirm mishandling by the patients.

On September 25, officials at the Florida Department of Health, the Hillsborough County Health Department, and

CDC were notified that a patient had been hospitalized in Tampa, Florida, on September 16, with respiratory failure and descending paralysis. On September 28, botulinum toxin type A was identified in the patient's serum. Circulating toxin persisted more than 10 days after illness onset in this completely paralyzed patient, indicating ingestion of a massive toxin dose. Accordingly, the patient was treated with antitoxin, which prevents binding of circulating botulinum toxin to nerve endings. The patient remains hospitalized, paralyzed, and on a ventilator. The Hillsborough County Health Department collected an open, 450-milliliter bottle of Bolthouse Farms carrot juice, which had been found by a family member in the hotel room where the patient had been staying during the month before being hospitalized. The hotel room had no refrigerator. The bottle, which had a "best if used by" date of September 19, 2006, had a different lot number than the bottle associated with the Georgia cases. On September 29, botulinum toxin was identified in carrot juice from the bottle found in the patient's hotel room; the toxin was subsequently identified as botulinum toxin type A. The Hillsborough County Health Department and CDC notified FDA, public health officials in all 50 states, and infection-control practitioners in Hillsborough County about the botulism case and implicated product. The manufacturer provided FDA with bottles of carrot juice from the same lot as the bottle found in the patient's room. FDA tested juice from all of these bottles, and it was negative for botulinum toxin.

C. botulinum spores are found in the environment and can be present naturally in carrot juice and other foods that have not undergone the retort canning process, which involves high temperatures and high pressure. Anaerobic conditions, low acidity (pH>4.6), low salt and sugar concentrations, and temperatures >39°F (>4°C) promote germination of *C. botulinum* spores and botulinum toxin production. Carrot juice has low acidity, with a natural pH of approximately 6.0; therefore, in the absence of another inhibitor, refrigeration at temperatures <40°F (<4°C) is necessary to prevent germination of *C. botulinum* spores and production of botulinum toxin. Inhibiting *C. botulinum* growth in other ways, such as through acidification, can retard its growth in juice that is not properly refrigerated.

Acidification has been used as a solution to previous foodborne botulism outbreaks. In 1985, 36 patients in the United States and Canada were identified with botulism after eating at a restaurant in Vancouver, British Columbia. A case-control study implicated commercially produced, chopped garlic in soybean oil stored at room temperature as the source of the outbreak (*1*). In 1989, a second outbreak of botulism associated with chopped garlic in oil occurred when three patients in New York were identified with botulism after consuming a meal containing unrefrigerated, commercially produced, chopped garlic in virgin olive oil (*2*). After these outbreaks, FDA rules were altered to require that garlic-in-oil products contain an acidifying agent such as phosphoric or citric acid.

The carrot juice consumed by these four patients was manufactured by Bolthouse Farms, Inc., and distributed in all 50 states, Mexico, Canada, and Hong Kong with the labels "Bolthouse Farms 100% Carrot Juice," "Earthbound Farm Organic Carrot Juice," and "President's Choice Organics 100% Pure Carrot Juice." Investigations of these cases by state and local health departments and investigations of the manufacturer by FDA are ongoing. On September 29, GDPH and the Georgia Department of Agriculture recommended that Georgia residents not purchase or consume Bolthouse Farms carrot juice. The same day, the FDA warned consumers not to drink Bolthouse Farms carrot juice with "best if used by" dates of November 11, 2006 or earlier (i.e., all bottles produced before the date the warning was issued), and Bolthouse Farms issued a voluntary recall of these products. Additional information regarding the recall is available from the Bolthouse Farms website at http://www.bolthouse.com/bolthouserecallFAQ.pdf or from FDA (telephone, 888-723-3366).

Suspected botulism cases should be reported immediately to local or state public health officials, who then should call the 24-hour CDC Emergency Operations Center at 770-488-7100; the center will immediately connect them with an on-call botulism specialist. Health-care providers and public health officials are encouraged to inquire specifically about consumption of carrot juice as part of the food history of suspect botulism cases. Additional information on botulism is available at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/botulism_g.htm.

Reported by: *C Shuler, DVM, C Drenzek, DVM, S Lance, DVM, PhD, G Gonzalez, MD, J Miller, MSPH, M Tobin-D'Angelo, MD, J Gabel, DVM, C Burnett, MPH, Georgia Div of Public Health. D Atrubin, MPH, Florida Dept of Health. J Sobel, MD, P Juliao, PhD, S Maslanka, PhD, Div of Foodborne, Bacterial, and Mycotic Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases; P Wiersma, MD, A Sheth, MD, EIS officers, CDC.*

References

1. St Louis ME, Peck SH, Bowering D, et al. Botulism from chopped garlic: delayed recognition of a major outbreak. Ann Intern Med 1998;108:363–8.
2. Morse DL, Pickard LK, Guzewich JJ, et al. Garlic-in-oil associated botulism: episode leads to product modification. Am J Public Health 1990;80:1372–3.

Notice to Readers

Availability of Provisional AIDS and HIV/AIDS Data in *MMWR* Table IV and Pediatric HIV Surveillance Data in *MMWR* Table I

CDC is upgrading the national HIV/AIDS surveillance data management system. Because of this transition, CDC will not update AIDS or HIV/AIDS surveillance data for display in quarterly *MMWR* Table IV for the last two quarters of 2006. In addition, CDC will not provide monthly updates of HIV infection data for persons aged <13 years in *MMWR* Table I for the remainder of this year. Explanatory footnotes will be included with Tables I and IV during the period when no updates are available.

Erratum: Vol. 55, No. 35

In the *MMWR* report, "Update: Delayed-Onset *Pseudomonas fluorescens* Bloodstream Infections After Exposure to Contaminated Heparin Flush — Michigan and South Dakota, 2005–2006," the last line of the first column on page 961 should read, "The patients all had indwelling central venous catheters and received treatment during **October 2004–February 2005** at clinics known to have used the contaminated flush."

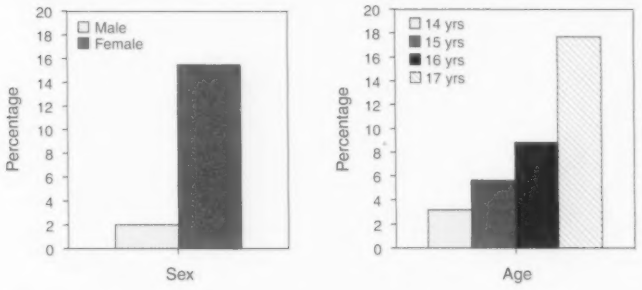
Erratum: Vol. 55, No. 39

In the *MMWR* report, "Childhood Influenza Vaccination Coverage — United States, 2004–05 Influenza Season," on page 1061, an error occurred in the fifth sentence of the first paragraph. The sentence should read, "Others recommended to receive influenza vaccination include children aged **5–18** years who have certain high-risk medical conditions, are on chronic aspirin therapy, or who are household contacts of persons at high risk for influenza complications (*1*)."

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Teens Aged 14–17 Years Who Used Indoor Tanning Devices During the Preceding 12 Months, by Sex and Age — United States, 2005*



*Data are based on household interviews of a sample of the civilian, noninstitutionalized population.

The World Health Organization recommends that no person aged <18 years use a tanning bed because of the associated increased risk for skin cancer. In addition, CDC recommends that school programs to prevent skin cancer advise students to avoid using sunlamps and tanning beds. Nonetheless, in 2005, 8.7% of teens aged 14–17 years used indoor tanning devices. Girls aged 14–17 years were seven times more likely to use these devices than boys in the same age group. The use of indoor tanning devices increased with age from 14 to 17 years.

SOURCES: National Health Interview Survey, 2005. Available at http://www.cdc.gov/nchs/nhis.htm.

World Health Organization. The World Health Organization recommends that no person under 18 should use a sunbed. Available at http://www.who.int/mediacentre/news/notes/2005/np07/en/index.html.

CDC. Guidelines for school programs to prevent skin cancer. MMWR 2002;51(No. RR-4).

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending October 7, 2006 (40th Week)*

Disease	Current week	Cum 2006	5-year weekly average†	Total cases reported for previous years 2005	2004	2003	2002	2001	States reporting cases during current week (No.)
Anthrax	—	1	0	—	—	—	2	23	
Botulism:									
foodborne	1	8	0	19	16	20	28	39	FL (1)
infant	1	64	2	90	87	76	69	97	UT (1)
other (wound & unspecified)	—	42	1	33	30	33	21	19	
Brucellosis	—	78	2	122	114	104	125	136	
Chancroid	—	23	0	17	30	54	67	38	
Cholera	—	6	0	8	5	2	2	3	
Cyclosporiasis§	—	91	1	734	171	75	156	147	
Diphtheria	—	—	—	—	—	1	1	2	
Domestic arboviral diseases§,¶:									
California serogroup	—	33	5	80	112	108	164	128	
eastern equine	—	6	0	21	6	14	10	9	
Powassan	—	1	—	1	1	—	1	N	
St. Louis	—	3	1	13	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	3	282	8	790	537	362	511	261	NY (1), PA (1), AL (1)
human monocytic	4	281	8	522	338	321	216	142	NY (1), MO (2), TN (1)
human (other & unspecified)	1	130	1	122	59	44	23	6	MO (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	8	0	9	19	32	34	—	
nonserotype b	2	67	2	135	135	117	144	—	CT (1), OK (1)
unknown serotype	1	152	2	217	177	227	153	—	ID (1)
Hansen disease§	3	55	1	88	105	95	96	79	NH (1), FL (2)
Hantavirus pulmonary syndrome§	1	25	0	29	24	26	19	8	AZ (1)
Hemolytic uremic syndrome, postdiarrheal§	7	183	5	221	200	178	216	202	OH (1), MN (2), NC (2), AL (1), UT (1)
Hepatitis C viral, acute	11	594	32	771	713	1,102	1,835	3,976	OH (2), MI (3), MO (1), MD (1), OK (1), TX (1), WA (1), OR (1)
HIV infection, pediatric (age <13 yrs)§,††	—	52	4	380	436	504	420	543	
Influenza-associated pediatric mortality§,§§,¶¶	—	40	0	45	—	N	N	N	
Listeriosis	7	498	19	892	753	696	665	613	NY (2), PA (1), OH (1), FL (1), AL (1), WA (1)
Measles	—***	43	0	66	37	56	44	116	
Meningococcal disease,††† invasive:									
A, C, Y, & W-135	1	170	3	297	—	—	—	—	WA (1)
serogroup B	—	108	2	157	—	—	—	—	
other serogroup	—	14	0	27	—	—	—	—	
Mumps	9	5,791	5	314	258	231	270	266	NY (1), PA (1), MO (1), NC (6)
Plague	1	12	0	8	3	1	2	2	UT (1)
Poliomyelitis, paralytic	—	—	0	1	—	—	—	—	
Psittacosis§	—	17	0	19	12	12	18	25	
Q fever§	4	120	1	139	70	71	61	26	MO (2), TN (1), TX (1)
Rabies, human	—	1	0	2	7	2	3	1	
Rubella	1	8	0	11	10	7	18	23	NY (1)
Rubella, congenital syndrome	—	1	—	1	—	1	1	3	
SARS-CoV§,§§	—	—	—	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	78	1	129	132	161	118	77	
Streptococcus pneumoniae,§									
invasive disease (age <5 yrs)	15	787	11	1,257	1,162	845	513	498	NY (3), MI (2), MN (2), NE (2), OK (1), TX (2), CO (3)
Syphilis, congenital (age <1 yr)	5	205	8	361	353	413	412	441	NY (2), IL (1), NC (1), AZ (1)
Tetanus	—	17	0	27	34	20	25	37	
Toxic-shock syndrome (other than streptococcal)§	—	72	2	96	95	133	109	127	
Trichinellosis	—	11	0	19	5	6	14	22	
Tularemia§	—	68	3	154	134	129	90	129	
Typhoid fever	—	220	9	324	322	356	321	368	
Vancomycin-intermediate *Staphylococcus aureus*§	—	2	—	2	—	N	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	0	3	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting year 2006 is provisional, whereas data for 2001, 2002, 2003, 2004, and 2005 are finalized.

† Calculated by summing the incidence counts for the current week, the two weeks preceding the current week, and the two weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

§ Not notifiable in all states.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance).

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (proposed). Implementation of HIV reporting influences the number of cases reported. Pediatric HIV data will not be updated monthly for the remainder of this year due to upgrading of the national HIV/AIDS surveillance data management system. Data for HIV/AIDS are available in Table IV quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases (proposed).

¶¶ Cumulative totals for 2005 and 2006 do not include reports from states where influenza-associated pediatric mortality is not a notifiable condition.

*** No measles cases were reported for the current week.

††† Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

MMWR™ QuickGuide

Weekly October 13, 2006 / Vol. 55 / No. 40

Recommended Adult Immunization Schedule — United States, October 2006–September 2007

The Advisory Committee on Immunization Practices (ACIP) annually reviews the recommended Adult Immunization Schedule to ensure that the schedule reflects current recommendations for the licensed vaccines. In June 2006, ACIP approved the Adult Immunization Schedule for October 2006–September 2007. This schedule has also been approved by the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists.

Changes in the Schedule for October 2006–September 2007

The 2006–2007 schedule differs from the previous schedule as follows:

- The broken red line has been deleted on the age-based schedule (Figure 1). Vaccination of persons with specific risk factors is now shown only with purple bars.
- Human papillomavirus (HPV) vaccine has been added to the age-based schedule, with a yellow bar indicating that the vaccine is recommended for women ≤26 years.
- Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine has been added to the age-based schedule, with a hatched yellow bar indicating that Tdap is a one-time, 1-dose recommendation for persons ≤64 years.
- The purple bar for varicella vaccine has been shortened in anticipation of the recommendation for the use of zoster vaccine in persons aged ≥60 years.
- A new column has been added to the medical/other indications schedule (Figure 2) to clarify indications for hepatitis A and B vaccines. The indications "chronic liver disease" and "recipients of clotting factor concentrates" have been removed from the previous schedule's third and fifth columns, respectively, and combined into a new column. The column has a yellow bar for hepatitis A and B vaccines, clarifying that these vaccines are recommended for all persons with these medical indications.
- HPV vaccine has been added to the medical/other indications schedule, with a yellow bar to indicate the vaccine is recommended for women aged ≤26 years with all indications except pregnancy.
- Tdap was added to the medical/other indications schedule, with a hatched yellow bar to indicate that Tdap is a one-time, 1-dose recommendation for all indications except pregnancy.
- The tetanus and diphtheria footnote (#1) has been reworded to reflect ACIP recommendations for use of Tdap.
- A footnote (#2) has been added to reflect ACIP recommendations for HPV vaccination for all women aged ≤26 years.
- The measles, mumps, and rubella (MMR) footnote (#3) has been reworded to reflect ACIP recommendations to administer a second dose of mumps vaccine to adults in certain age groups and with certain risk factors.
- The varicella footnote (#4) has been reworded in accordance with ACIP recommendations for administering a routine second dose for all adults without evidence of immunity. The footnote also has been revised to reflect the new definition of immunity to varicella.
- The influenza footnote (#5) has been revised to reflect recent ACIP recommendations to vaccinate close contacts of children aged 0–59 months rather than 0–23 months (*1*).
- The hepatitis B footnote (#9) has been revised to reflect recommendations to vaccinate any adult seeking protection from hepatitis B virus infection and vaccinate adults in specific settings (e.g., sexually transmitted disease clinics) (*2*).

The Adult Immunization Schedule is available in English and Spanish at http://www.cdc.gov/nip/recs/adult-schedule.htm. General information about adult vaccinations, including recommendations concerning vaccination of person with HIV and other immunosuppressive conditions, is available from state and local health departments and at http://www.cdc.gov/nip. Vaccine information statements are available at http://www.cdc.gov/nip/publications/vis. ACIP statements for each recommended vaccine and provisional vaccine recommendations can be viewed, downloaded, and printed at http://www.cdc.gov/nip/publications/acip-list.htm. Instructions for reporting adverse events to the Vaccine Adverse Event Reporting System are available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

The Recommended Adult Immunization Schedule has been approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians. The standard *MMWR* footnote format has been modified for publication of this schedule.

Suggested citation: Centers for Disease Control and Prevention. Recommended Adult Immunization Schedule—United States, October 2006–September 2007. MMWR 2006;55:Q1–Q4.

References

1. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2006;55(No. RR-10).
2. CDC. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices (ACIP). Part II: immunization of adults. MMWR. In press 2006.

FIGURE 1. Recommended adult immunization schedule, by vaccine and age group — United States, October 2006–September 2007

Vaccine	Age group (yrs) 19–49	50–64	≥65
Tetanus, diphtheria, pertussis (Td/Tdap)[1]*	1-dose Td booster every 10 yrs; Substitute 1 dose of Tdap for Td		
Human papillomavirus (HPV)[2]*	3 doses (females)		
Measles, mumps, rubella (MMR)[3]*	1 or 2 doses	1 dose	
Varicella[4]*	2 doses (0, 4–8 wks)	2 doses (0, 4–8 wks)	
Influenza[5]*	1 dose annually	1 dose annually	
Pneumococcal (polysaccharide)[6,7]	1–2 doses		1 dose
Hepatitis A[8]*	2 doses (0, 6–12 mos, or 0, 6–18 mos)		
Hepatitis B[9]*	3 doses (0, 1–2, 4–6 mos)		
Meningococcal[10]	1 or more doses		

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

* Covered by the Vaccine Injury Compensation Program.

NOTE: These recommendations must be read along with the footnotes, which can be found on pages Q2–Q4 of this schedule.

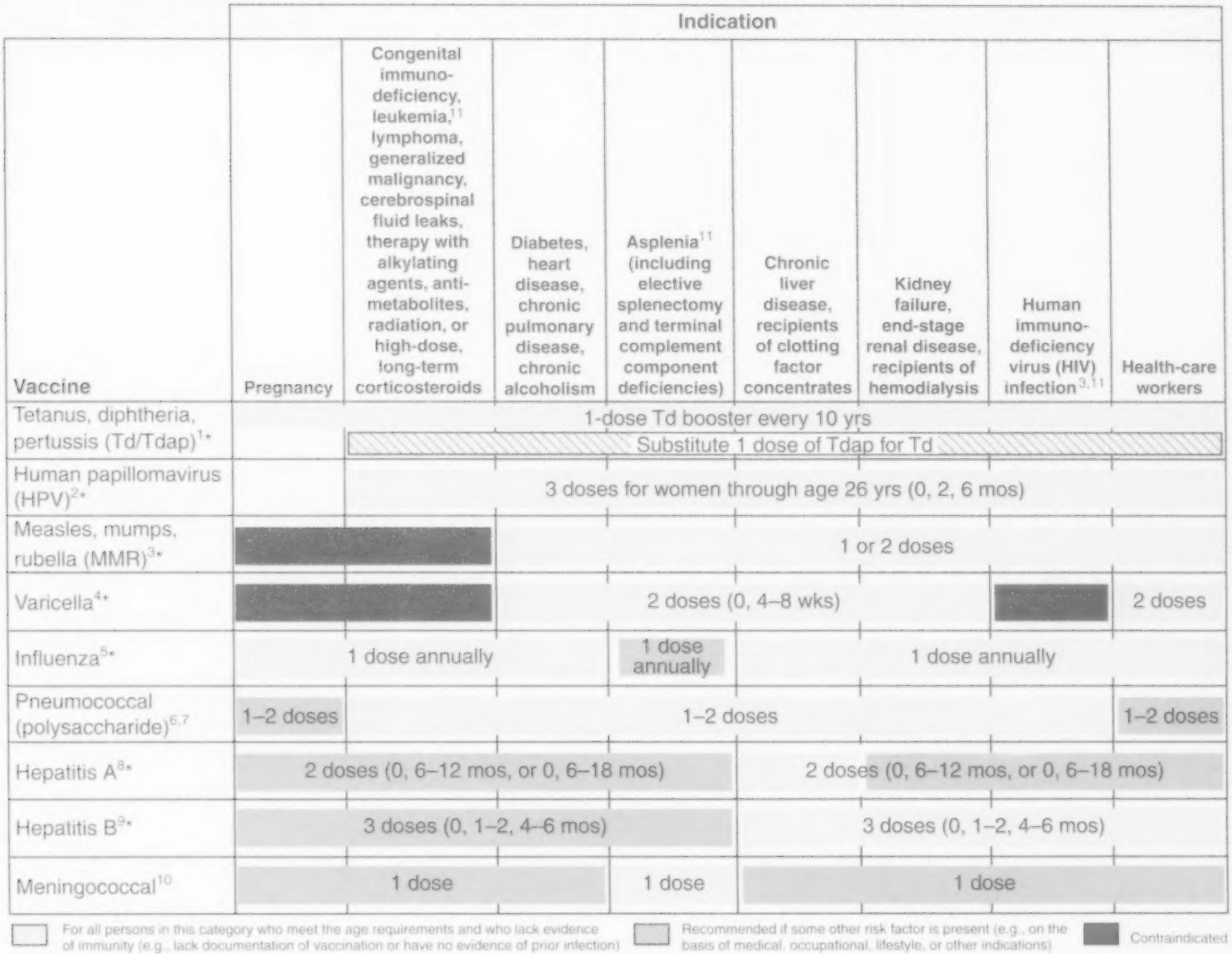
Approved by the Advisory Committee on Immunization Practices, the American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians

1. Tetanus, diphtheria, and acellular pertussis (Td/Tdap) vaccination. Adults with uncertain histories of a complete primary vaccination series with diphtheria and tetanus toxoid–containing vaccines should begin or complete a primary vaccination series. A primary series for adults is 3 doses; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. Administer a booster dose to adults who have completed a primary series and if the last vaccination was received ≥10 years previously. Tdap or tetanus and diphtheria (Td) vaccine may be used; Tdap should replace a single dose of Td for adults aged <65 years who have not previously received a dose of Tdap (either in the primary series, as a booster, or for wound management). Only one of two Tdap products (Adacel® [sanofi pasteur, Swiftwater, Pennsylvania]) is licensed for use in adults. If the person is pregnant and received the last Td vaccination ≥10 years previously, administer Td during the second or third trimester; if the person received the last Td vaccination in <10 years, administer Tdap during the immediate postpartum period. A one-time administration of 1-dose of Tdap with an interval as short as 2 years from a previous Td vaccination is recommended for postpartum women, close contacts of infants aged <12 months, and all health-care workers with direct patient contact. In certain situations, Td can be deferred during pregnancy and Tdap substituted in the immediate postpartum period, or Tdap can be given instead of Td to a pregnant woman after an informed discussion with the woman (see http://www.cdc.gov/nip/publications/acip-list.htm). Consult the ACIP statement for recommendations for administering Td as prophylaxis in wound management (http://www.cdc.gov/mmwr/preview/mmwrhtml/00041645.htm).

2. Human papillomavirus (HPV) vaccination. HPV vaccination is recommended for all women aged ≤26 years who have not completed the vaccine series. Ideally, vaccine should be administered before potential exposure to HPV through sexual activity; however, women who are sexually active should still be vaccinated. Sexually active women who have not been infected with any of the HPV vaccine types receive the full benefit of the vaccination. Vaccination is less beneficial for women who have already been infected with one or more of the four HPV vaccine types. A complete series consists of 3 doses. The second dose should be administered 2 months after the first dose; the third dose should be administered 6 months after the first dose. Vaccination is not recommended during pregnancy. If a woman is found to be pregnant after initiating the vaccination series, the remainder of the 3-dose regimen should be delayed until after completion of the pregnancy.

3. Measles, mumps, rubella (MMR) vaccination. *Measles component:* adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive ≥1 dose of MMR unless they have a medical contraindication, documentation of ≥1 dose, history of measles based on health-care provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) have been recently exposed to measles or in an outbreak setting; 2) have been previously vaccinated with killed measles vaccine; 3) have been vaccinated with an unknown type of measles vaccine during 1963–1967; 4) are students in postsecondary educational institutions; 5) work in a health-care facility; or 6) plan to travel internationally. Withhold MMR or other measles-containing vaccines from HIV-infected persons with severe immunosuppression. *Mumps component:* adults born before 1957 can generally be considered immune to mumps. Adults born during or after 1957 should receive 1 dose of MMR unless they have a medical contraindication, history of mumps based on health-care provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) are in an age group that is affected during a mumps outbreak; 2) are students in postsecondary educational institutions; 3) work in a health-care facility; or 4) plan to travel internationally. For unvaccinated health-care workers born before 1957 who do not have other evidence of

FIGURE 2. Recommended adult immunization schedule, by vaccine and medical and other indications — United States, October 2006–September 2007


Indication
Vaccine
Pregnancy
Congenital immunodeficiency, leukemia,[11] lymphoma, generalized malignancy, cerebrospinal fluid leaks, therapy with alkylating agents, antimetabolites, radiation, or high-dose, long-term corticosteroids
Diabetes, heart disease, chronic pulmonary disease, chronic alcoholism
Asplenia[11] (including elective splenectomy and terminal complement component deficiencies)
Chronic liver disease, recipients of clotting factor concentrates
Kidney failure, end-stage renal disease, recipients of hemodialysis
Human immunodeficiency virus (HIV) infection[3,11]
Health-care workers
Tetanus, diphtheria, pertussis (Td/Tdap)[1]*
1-dose Td booster every 10 yrs
Substitute 1 dose of Tdap for Td
Human papillomavirus (HPV)[2]*
3 doses for women through age 26 yrs (0, 2, 6 mos)
Measles, mumps, rubella (MMR)[3]*
1 or 2 doses
Varicella[4]*
2 doses (0, 4–8 wks)
2 doses
Influenza[5]*
1 dose annually
1 dose annually
1 dose annually
Pneumococcal (polysaccharide)[6,7]
1–2 doses
1–2 doses
1–2 doses
Hepatitis A[8]*
2 doses (0, 6–12 mos, or 0, 6–18 mos)
2 doses (0, 6–12 mos, or 0, 6–18 mos)
Hepatitis B[9]*
3 doses (0, 1–2, 4–6 mos)
3 doses (0, 1–2, 4–6 mos)
Meningococcal[10]
1 dose
1 dose
1 dose
For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)
Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
Contraindicated

* Covered by the Vaccine Injury Compensation Program.

NOTE: These recommendations must be read along with the footnotes, which can be found on pages Q2–Q4 of this schedule.

mumps immunity, consider giving 1 dose on a routine basis and strongly consider giving a second dose during an outbreak. *Rubella component:* administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Do not vaccinate women who are pregnant or who might become pregnant within 4 weeks of receiving vaccine. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the health-care facility.

4. Varicella vaccination. All adults without evidence of immunity to varicella should receive 2 doses of varicella vaccine. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (e.g., health-care workers and family contacts of immunocompromised persons) or 2) are at high risk for exposure or transmission (e.g., teachers of young children; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; non-pregnant women of childbearing age; and international travelers). Evidence of immunity to varicella in adults includes any of the following: 1) documentation of 2 doses of varicella vaccine at least 4 weeks apart; 2) U.S.-born before 1980 (although for health-care workers and pregnant women, birth before 1980 should not be considered evidence of immunity); 3) history of varicella based on diagnosis or verification of varicella by a health-care provider (for a patient reporting a history of or presenting with an atypical case, a mild case, or both, health-care providers should seek either an epidemiologic link with a typical varicella case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on health-care provider diagnosis; or 5) laboratory evidence of immunity or laboratory confirmation of disease. Do not vaccinate women who are pregnant or might become pregnant within 4 weeks of receiving the vaccine. Assess pregnant women for evidence of varicella immunity. Women who do not have evidence of immunity should receive dose 1 of varicella vaccine upon completion or termination of pregnancy and before discharge from the health-care facility. Dose 2 should be administered 4–8 weeks after dose 1.

5. Influenza vaccination. *Medical indications:* chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or HIV); any condition that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration (e.g., cognitive dysfunction, spinal cord injury, or seizure disorder or other neuromuscular disorder); and pregnancy during the influenza season. No data exist on the risk for severe or complicated influenza disease among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia. *Occupational indications:* health-care workers and employees of long-term–care and assisted living facilities. *Other indications:* residents of nursing homes and other long-term–care and assisted living facilities; persons likely to transmit influenza to persons at high risk (i.e., in-home household contacts and caregivers of children aged 0–59 months, or persons of all ages with high-risk conditions); and anyone who would like to be vaccinated. Healthy, nonpregnant persons aged 5–49 years without high-risk medical conditions who are not contacts of severely immunocompromised persons in special care units can receive either intranasally administered influenza vaccine (FluMist®) or inactivated vaccine. Other persons should receive the inactivated vaccine.

6. Pneumococcal polysaccharide vaccination. *Medical indications:* chronic disorders of the pulmonary system (excluding asthma); cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection [vaccinate as close to diagnosis as possible when CD4 cell counts are highest], leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, or organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids; and cochlear implants. *Other indications:* Alaska Natives and certain American Indian populations and residents of nursing homes or other long-term–care facilities.

7. Revaccination with pneumococcal polysaccharide vaccine. One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, or organ or bone marrow transplantation); or chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids. For persons aged ≥65 years, one-time revaccination if they were vaccinated ≥5 years previously and were aged <65 years at the time of primary vaccination.

8. Hepatitis A vaccination. *Medical indications:* persons with chronic liver disease and persons who receive clotting factor concentrates. *Behavioral indications:* men who have sex with men and persons who use illegal drugs. *Occupational indications:* persons working with hepatitis A virus (HAV)–infected primates or with HAV in a research laboratory setting. *Other indications:* persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (a list of countries is available at http://www.cdc.gov/travel/diseases.htm) and any person who would like to obtain immunity. Current vaccines should be administered in a 2-dose schedule at either 0 and 6–12 months, or 0 and 6–18 months. If the combined hepatitis A and hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months.

9. Hepatitis B vaccination. *Medical indications:* persons with end-stage renal disease, including patients receiving hemodialysis; persons seeking evaluation or treatment for a sexually transmitted disease (STD); persons with HIV infection; persons with chronic liver disease; and persons who receive clotting factor concentrates. *Occupational indications:* health-care workers and public-safety workers who are exposed to blood or other potentially infectious body fluids. *Behavioral indications:* sexually active persons who are not in a long-term, mutually monogamous relationship (i.e., persons with >1 sex partner during the previous 6 months); current or recent injection-drug users; and men who have sex with men. *Other indications:* household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff members of institutions for persons with developmental disabilities; all clients of STD clinics; international travelers to countries with high or intermediate prevalence of chronic HBV infection (a list of countries is available at http://www.cdc.gov/travel/diseases.htm); and any adult seeking protection from HBV infection. Settings where hepatitis B vaccination is recommended for all adults: STD treatment facilities; HIV testing and treatment facilities; facilities providing drug-abuse treatment and prevention services; health-care settings providing services for injection-drug users or men who have sex with men; correctional facilities; end-stage renal disease programs and facilities for chronic hemodialysis patients; and institutions and nonresidential daycare facilities for persons with developmental disabilities. *Special formulation indications:* for adult patients receiving hemodialysis and other immunocompromised adults, 1 dose of 40 μg/mL (Recombivax HB®) or 2 doses of 20 μg/mL (Engerix-B®).

10. Meningococcal vaccination. *Medical indications:* adults with anatomic or functional asplenia, or terminal complement component deficiencies. *Other indications:* first-year college students living in dormitories; microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*; military recruits; and persons who travel to or live in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the "meningitis belt" of sub-Saharan Africa during the dry season [December–June]), particularly if their contact with local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj. Meningococcal conjugate vaccine is preferred for adults with any of the preceding indications who are aged ≤55 years, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Revaccination after 5 years might be indicated for adults previously vaccinated with MPSV4 who remain at high risk for infection (e.g., persons residing in areas in which disease is epidemic).

11. Selected conditions for which *Haemophilus influenzae* type b (Hib) vaccine may be used. Hib conjugate vaccines are licensed for children aged 6 weeks–71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with the chronic conditions associated with an increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection or who have had splenectomies; administering vaccine to these patients is not contraindicated.

This schedule indicates the recommended age groups and medical indications for routine administration of currently licensed vaccines for persons aged ≥19 years, as of October 1, 2006. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers' package inserts and the complete statements from the Advisory Committee on Immunization Practices (http://www.cdc.gov/nip/publications/acip-list.htm).

Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

Information on how to file a Vaccine Injury Compensation Program claim is available at http://www.hrsa.gov/vaccinecompensation or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005; telephone, 202-357-6400.

Additional information about the vaccines in this schedule and contraindications for vaccination is also available at http://www.cdc.gov/nip or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 24 hours a day, 7 days a week.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	10,833	18,961	35,170	723,079	736,812	10	149	1,643	6,216	3,222	111	69	594	3,594	5,738
New England	1,068	623	1,550	24,919	24,817	—	0	0	—	—	8	4	29	235	285
Connecticut	400	167	1,214	7,196	7,275	N	0	0	N	N	—	0	26	26	64
Maine§	51	43	74	1,725	1,714	N	0	0	N	N	—	0	4	32	25
Massachusetts	543	284	442	11,392	11,086	—	0	0	—	—	—	1	14	88	129
New Hampshire	51	37	65	1,511	1,424	—	0	0	—	—	4	1	4	36	30
Rhode Island	—	60	100	2,244	2,572	—	0	0	—	—	—	0	6	11	7
Vermont§	23	19	43	851	746	N	0	0	N	N	4	0	5	42	30
Mid. Atlantic	1,475	2,380	3,696	91,650	90,744	—	0	0	—	—	3	11	444	403	2,286
New Jersey	132	375	497	14,080	14,850	N	0	0	N	N	—	0	3	9	52
New York (Upstate)	444	499	1,727	18,506	17,969	N	0	0	N	N	2	3	441	130	1,900
New York City	439	731	1,570	29,148	29,441	N	0	0	N	N	—	1	9	50	118
Pennsylvania	460	739	1,074	29,916	28,484	N	0	0	N	N	1	5	13	214	216
E.N. Central	1,836	3,123	12,578	121,131	123,466	—	1	3	37	9	18	16	109	878	1,364
Illinois	647	964	1,691	39,135	38,714	—	0	0	—	—	—	2	8	72	141
Indiana	320	393	510	15,042	15,526	N	0	0	N	N	5	1	18	68	59
Michigan	684	645	9,888	26,632	20,545	—	0	3	33	9	2	2	7	102	89
Ohio	41	686	1,433	25,115	33,067	—	0	1	4	—	10	5	76	285	650
Wisconsin	144	399	531	15,207	15,614	N	0	0	N	N	1	5	52	351	425
W.N. Central	488	1,152	1,456	44,315	45,432	—	0	12	1	4	14	11	73	645	516
Iowa	—	154	225	5,730	5,484	N	0	0	N	N	—	1	28	151	113
Kansas	—	154	269	5,443	5,665	N	0	0	N	N	—	1	7	58	32
Minnesota	—	230	346	8,222	9,493	—	0	12	—	3	11	2	22	155	103
Missouri	332	441	612	17,497	17,469	—	0	1	1	1	1	2	18	145	221
Nebraska§	71	95	176	4,109	3,960	N	0	1	N	N	2	1	16	72	19
North Dakota	21	33	58	1,273	1,230	N	0	0	N	N	—	0	4	8	1
South Dakota	64	51	116	2,041	2,131	N	0	0	N	N	—	1	7	56	27
S. Atlantic	3,117	3,454	4,927	138,603	137,469	—	0	1	3	1	46	14	63	753	546
Delaware	63	68	92	2,714	2,572	N	0	0	N	N	—	0	3	11	3
District of Columbia	23	52	103	1,829	2,957	—	0	0	—	—	—	0	3	12	9
Florida	840	942	1,154	37,497	33,379	N	0	0	N	N	30	6	32	356	243
Georgia	1	635	2,142	22,464	24,134	—	0	0	—	—	4	3	11	154	113
Maryland§	307	331	486	13,456	14,176	—	0	1	3	1	—	0	3	15	26
North Carolina	1,017	562	1,772	25,920	24,902	N	0	0	N	N	8	0	11	79	69
South Carolina§	349	306	1,306	13,895	14,846	N	0	0	N	N	4	1	13	81	18
Virginia§	495	423	840	18,390	18,458	N	0	0	N	N	—	1	6	38	53
West Virginia	22	57	226	2,438	2,045	N	0	0	N	N	—	0	3	7	12
E.S. Central	552	1,419	1,947	55,669	53,492	—	0	0	—	—	11	3	20	140	173
Alabama§	—	391	756	15,314	11,982	N	0	0	N	N	10	1	7	61	21
Kentucky	4	160	402	6,427	6,858	N	0	0	N	N	1	1	19	31	117
Mississippi	—	382	802	14,283	16,599	—	0	0	—	—	—	0	3	14	2
Tennessee§	548	495	599	19,645	18,053	N	0	0	N	N	—	1	5	34	33
W.S. Central	615	2,151	3,605	82,185	84,961	—	0	1	1	—	4	4	26	194	185
Arkansas	181	158	333	6,270	6,692	—	0	0	—	—	1	0	2	18	4
Louisiana	225	265	761	11,278	12,966	—	0	1	1	N	—	0	7	41	72
Oklahoma	209	228	2,159	9,209	8,735	N	0	0	N	N	3	1	4	32	36
Texas§	—	1,392	1,774	55,428	56,568	N	0	0	N	N	—	2	20	103	73
Mountain	1,300	1,027	1,839	38,608	48,496	10	114	452	4,330	2,100	5	2	38	280	111
Arizona	881	354	642	14,119	16,579	10	111	448	4,256	2,020	—	0	2	19	9
Colorado	62	156	482	4,512	11,670	N	0	0	N	N	2	1	7	58	38
Idaho§	191	50	159	2,236	1,998	N	0	0	N	N	1	0	5	25	13
Montana	—	42	195	1,825	1,775	N	0	0	N	N	—	0	26	104	16
Nevada§	166	77	432	3,732	5,642	—	0	4	21	48	—	0	1	4	11
New Mexico§	—	172	339	7,422	6,504	—	0	3	13	16	—	0	4	16	10
Utah	—	94	170	3,731	3,457	—	1	3	38	13	2	0	3	16	11
Wyoming	—	27	55	1,031	871	—	0	2	2	3	—	0	11	38	3
Pacific	382	3,315	5,079	125,999	127,935	—	43	1,179	1,844	1,108	2	2	52	66	272
Alaska	57	85	152	3,247	3,263	—	0	0	—	—	—	0	1	4	3
California	—	2,570	4,231	98,604	99,331	—	43	1,179	1,844	1,108	—	0	14	—	156
Hawaii	—	103	135	3,948	4,264	N	0	0	N	N	—	0	1	4	1
Oregon§	—	174	315	6,624	6,836	N	0	0	N	N	2	1	6	58	60
Washington	325	350	604	13,576	14,241	N	0	0	N	N	—	0	38	—	52
American Samoa	U	0	46	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	18	37	—	629	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	75	161	2,945	3,187	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	5	16	178	196	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	297	322	1,029	12,510	14,626	3,548	6,499	14,136	250,416	252,809	14	38	142	1,550	1,777
New England	23	24	75	967	1,331	145	107	288	4,211	4,476	1	2	19	127	136
Connecticut	8	0	37	222	280	82	41	241	1,698	1,908	1	0	9	38	40
Maine†	6	2	13	133	168	2	2	6	98	110	—	0	4	17	8
Massachusetts	—	10	25	357	602	58	46	86	1,855	1,936	—	1	7	52	68
New Hampshire	1	0	9	24	50	1	4	9	149	127	—	0	2	7	7
Rhode Island	—	0	25	92	86	—	8	19	360	350	—	0	7	4	7
Vermont†	8	3	10	139	145	2	1	4	51	45	—	0	2	9	6
Mid. Atlantic	39	61	254	2,239	2,646	448	636	1,014	24,324	26,068	2	7	30	299	333
New Jersey	—	9	13	297	351	88	102	143	3,767	4,399	—	1	4	45	67
New York (Upstate)	27	24	227	911	909	107	123	455	4,787	5,240	2	2	27	103	97
New York City	2	10	31	438	708	98	175	357	7,198	7,873	—	1	4	36	61
Pennsylvania	10	15	29	593	678	155	215	394	8,572	8,556	—	3	8	115	108
E.N. Central	28	49	86	1,846	2,612	654	1,285	7,047	49,286	50,104	2	5	14	219	308
Illinois	—	9	21	317	615	207	377	709	14,969	15,252	—	1	6	47	104
Indiana	N	0	0	N	N	137	161	237	6,713	6,259	2	1	11	66	54
Michigan	3	14	22	502	631	262	252	5,880	11,097	8,512	—	0	3	18	19
Ohio	25	16	32	624	605	15	329	648	11,390	15,637	—	2	6	65	94
Wisconsin	—	10	40	403	761	33	134	172	5,117	4,444	—	0	4	23	37
W.N. Central	19	29	260	1,423	1,614	173	364	436	14,024	14,447	2	2	15	112	88
Iowa	1	5	15	223	215	—	33	46	1,199	1,219	—	0	1	1	—
Kansas	—	3	11	148	158	—	44	124	1,519	2,010	—	0	3	14	9
Minnesota	—	2	238	477	667	—	62	105	2,113	2,660	—	0	9	56	37
Missouri	15	10	32	420	365	155	190	251	7,753	7,309	2	0	6	30	29
Nebraska†	3	2	8	86	103	11	23	56	1,062	899	—	0	2	7	12
North Dakota	—	0	7	12	12	1	3	7	87	79	—	0	3	4	1
South Dakota	—	1	7	57	94	6	6	15	291	271	—	0	0	—	—
S. Atlantic	80	49	95	1,920	2,118	1,187	1,491	2,334	61,369	60,107	1	10	26	409	420
Delaware	—	1	4	33	44	27	27	44	1,132	663	—	0	1	1	—
District of Columbia	—	1	5	52	41	24	34	61	1,238	1,633	—	0	1	4	7
Florida	40	18	39	821	743	381	437	553	17,853	15,359	—	3	9	133	103
Georgia	29	10	44	411	565	4	300	1,014	10,865	11,261	1	2	12	80	90
Maryland†	8	4	11	158	161	102	128	186	5,022	5,324	—	1	5	53	58
North Carolina	N	0	0	N	N	332	284	766	13,093	11,903	—	0	9	46	68
South Carolina†	—	1	7	69	86	151	132	704	6,262	6,798	—	1	3	27	28
Virginia†	3	8	50	359	446	148	130	288	5,161	6,628	—	1	8	49	43
West Virginia	—	0	5	17	32	18	17	42	743	538	—	0	4	16	23
E.S. Central	20	8	40	377	329	205	564	863	22,544	21,249	—	2	7	79	94
Alabama†	13	4	29	204	149	—	183	310	7,110	6,880	—	0	5	20	17
Kentucky	N	0	0	N	N	7	55	132	2,301	2,353	—	0	1	4	11
Mississippi	—	0	0	—	—	—	141	435	5,607	5,401	—	0	1	3	—
Tennessee†	7	4	12	173	180	198	187	237	7,526	6,615	—	1	4	52	66
W.S. Central	11	5	31	209	248	291	879	1,430	35,567	34,532	3	1	15	54	95
Arkansas	6	2	6	92	66	97	79	142	3,241	3,499	—	0	2	7	7
Louisiana	—	0	3	18	51	123	161	354	6,889	7,183	—	0	2	5	32
Oklahoma	5	2	24	99	131	71	82	764	3,440	3,482	3	1	14	40	51
Texas†	N	0	0	N	N	—	541	836	21,997	20,368	—	0	2	2	5
Mountain	47	30	56	1,230	1,147	362	217	552	8,715	10,447	2	4	8	158	183
Arizona	—	3	36	116	108	198	90	201	3,541	3,768	—	1	7	73	92
Colorado	21	9	33	439	400	84	41	90	1,595	2,459	1	1	4	42	37
Idaho†	7	3	11	134	111	15	2	10	132	84	1	0	1	4	4
Montana	—	2	11	79	58	—	2	20	145	121	—	0	0	—	—
Nevada†	—	1	6	41	83	65	24	194	1,230	2,215	—	0	1	—	14
New Mexico†	—	1	6	47	68	—	31	64	1,348	1,211	—	0	4	21	21
Utah	18	7	19	344	299	—	17	25	631	530	—	0	4	15	8
Wyoming	1	1	4	30	20	—	2	6	93	59	—	0	1	3	7
Pacific	30	59	202	2,299	2,581	83	807	963	30,376	31,379	1	2	15	93	120
Alaska	3	1	15	75	86	11	11	23	451	447	—	0	2	9	26
California	—	43	105	1,606	1,833	—	659	830	24,950	26,144	—	0	9	21	50
Hawaii	—	1	3	37	52	1	18	29	707	788	—	0	1	14	8
Oregon†	7	8	14	308	344	—	28	58	1,016	1,174	1	1	6	47	36
Washington	20	6	90	273	266	71	75	142	3,252	2,826	—	0	4	2	—
American Samoa	U	0	0	U	U	U	0	2	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	11	—	1	15	—	71	—	1	2	—	7
Puerto Rico	4	2	12	62	211	—	5	16	188	286	—	0	1	1	3
U.S. Virgin Islands	—	0	0	—	—	—	0	5	30	45	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	Hepatitis (viral, acute), by type										Legionellosis				
	A					B									
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	17	69	245	2,463	3,245	45	84	597	3,064	4,035	37	44	127	1,636	1,574
New England	—	3	20	144	371	—	1	9	49	119	9	2	12	99	106
Connecticut	—	1	2	34	43	—	0	3	—	39	9	0	8	38	22
Maine†	—	0	2	6	3	—	0	2	15	12	—	0	2	7	5
Massachusetts	—	1	13	51	234	—	0	5	14	39	—	1	6	27	49
New Hampshire	—	0	16	36	75	—	0	2	11	24	—	0	1	1	8
Rhode Island	—	0	4	9	10	—	0	4	8	1	—	0	10	20	16
Vermont†	—	0	2	8	6	—	0	1	1	4	—	0	3	6	6
Mid. Atlantic	4	7	18	270	525	3	8	55	317	527	16	13	42	553	537
New Jersey	—	2	7	61	109	—	2	8	80	195	—	1	10	61	91
New York (Upstate)	4	1	14	67	81	—	1	43	49	45	11	5	29	230	137
New York City	—	2	12	92	252	—	2	4	60	110	—	1	9	46	83
Pennsylvania	—	1	5	50	83	3	3	9	128	177	5	4	17	216	226
E.N. Central	2	7	12	224	284	2	8	24	311	438	2	8	25	335	326
Illinois	—	1	4	50	103	—	2	7	57	124	—	1	4	21	46
Indiana	1	0	5	23	14	—	0	17	42	33	—	0	3	24	21
Michigan	—	2	8	78	88	1	3	7	105	143	—	2	7	86	89
Ohio	1	1	4	45	41	1	2	10	101	104	2	4	19	171	141
Wisconsin	—	1	5	28	38	—	0	4	6	34	—	0	5	33	29
W.N. Central	1	2	30	103	70	—	4	22	125	213	—	1	15	52	63
Iowa	—	0	2	8	18	—	0	3	14	21	—	0	3	10	4
Kansas	—	0	5	24	13	—	0	2	8	24	—	0	2	3	2
Minnesota	—	0	29	9	3	—	0	13	17	29	—	0	11	11	16
Missouri	1	1	3	39	28	—	2	7	74	111	—	0	3	18	24
Nebraska†	—	0	3	15	8	—	0	1	11	22	—	0	2	6	3
North Dakota	—	0	2	—	—	—	0	0	—	—	—	0	1	—	2
South Dakota	—	0	3	8	—	—	0	1	1	6	—	0	6	4	12
S. Atlantic	6	11	29	419	572	12	23	66	889	1,081	6	9	19	322	304
Delaware	—	0	2	10	5	—	1	4	35	25	—	0	2	8	13
District of Columbia	—	0	2	6	3	—	0	2	5	10	—	0	5	16	9
Florida	4	4	13	165	228	8	8	19	322	370	2	3	9	130	84
Georgia	—	1	7	50	108	1	3	7	124	166	—	0	4	15	27
Maryland†	1	1	6	53	58	—	3	10	128	121	4	1	6	65	87
North Carolina	—	0	20	67	70	—	0	23	123	128	—	0	5	29	24
South Carolina†	—	0	2	17	34	3	2	7	63	121	—	0	1	2	11
Virginia†	1	1	11	46	63	—	1	18	43	113	—	1	7	49	35
West Virginia	—	0	3	5	3	—	0	18	46	27	—	0	3	8	14
E.S. Central	2	2	8	97	216	4	6	15	249	284	1	1	9	67	62
Alabama†	—	0	3	13	40	—	1	8	78	67	—	0	2	9	12
Kentucky	—	0	5	29	22	1	1	5	57	54	1	0	4	23	21
Mississippi	—	0	1	5	17	—	0	2	11	44	—	0	1	1	3
Tennessee†	2	1	5	50	137	3	2	8	103	119	—	1	7	34	26
W.S. Central	2	4	77	138	376	17	14	315	578	478	—	1	32	43	38
Arkansas	—	0	9	35	16	1	1	4	37	53	—	0	3	3	5
Louisiana	—	0	4	15	56	—	0	3	25	62	—	0	2	4	1
Oklahoma	2	0	2	6	4	12	0	17	43	37	—	0	3	1	7
Texas†	—	2	73	82	300	4	12	295	473	326	—	0	26	35	25
Mountain	—	5	18	192	253	—	4	39	126	429	3	2	7	95	79
Arizona	—	2	16	108	135	—	1	23	33	276	—	1	4	32	19
Colorado	—	1	4	33	34	—	1	5	29	44	1	0	2	21	17
Idaho†	—	0	2	9	20	—	0	2	10	12	1	0	3	11	3
Montana	—	0	3	9	7	—	0	7	—	3	—	0	1	5	5
Nevada†	—	0	2	7	19	—	0	4	15	42	—	0	2	4	17
New Mexico†	—	0	3	12	19	—	0	3	15	18	—	0	1	4	3
Utah	—	0	2	11	18	—	0	5	24	32	1	0	1	18	11
Wyoming	—	0	1	3	1	—	0	1	—	2	—	0	0	—	4
Pacific	—	19	163	876	578	7	9	61	420	466	—	1	9	70	59
Alaska	—	0	0	—	4	—	0	1	5	7	—	0	1	—	—
California	—	15	162	793	477	—	7	41	317	312	—	1	9	70	57
Hawaii	—	0	2	9	21	—	0	1	5	6	—	0	1	—	2
Oregon†	—	0	5	37	38	1	1	5	54	84	N	0	0	N	N
Washington	—	1	13	37	38	6	0	18	39	57	—	0	0	—	—
American Samoa	U	0	0	U	1	U	0	0	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	2	—	0	0	—	18	—	0	0	—	—
Puerto Rico	—	0	5	23	58	—	1	8	24	38	—	0	1	1	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	101	252	2,153	13,234	17,704	13	24	125	916	1,096
New England	29	37	780	2,217	3,094	—	1	11	44	63
Connecticut	11	13	753	1,519	491	—	0	5	11	16
Maine†	16	1	34	164	213	—	0	1	4	5
Massachusetts	—	1	35	33	2,129	—	0	3	19	34
New Hampshire	2	6	59	422	188	—	0	3	9	5
Rhode Island	—	0	5	1	32	—	0	8	—	2
Vermont†	—	1	14	78	41	—	0	1	1	1
Mid. Atlantic	62	153	1,176	7,681	10,314	2	4	13	163	297
New Jersey	—	22	168	1,656	3,111	—	1	3	28	69
New York (Upstate)	51	75	1,150	3,244	3,084	2	1	11	36	39
New York City	—	1	18	124	349	—	2	8	64	160
Pennsylvania	11	40	222	2,657	3,770	—	1	3	35	29
E.N. Central	1	10	134	1,161	1,605	2	2	7	101	117
Illinois	—	0	2	—	119	—	1	4	42	66
Indiana	—	0	3	16	26	—	0	3	9	4
Michigan	1	1	6	41	47	—	0	2	16	19
Ohio	—	1	6	38	49	2	0	3	27	18
Wisconsin	—	10	129	1,066	1,364	—	0	3	7	10
W.N. Central	—	7	168	497	646	—	0	32	33	43
Iowa	—	1	8	77	86	—	0	1	1	8
Kansas	—	0	2	4	3	—	0	2	6	5
Minnesota	—	5	167	398	539	—	0	30	14	11
Missouri	—	0	3	9	13	—	0	1	6	16
Nebraska†	—	0	1	8	3	—	0	1	4	3
North Dakota	—	0	3	—	—	—	0	1	1	—
South Dakota	—	0	1	1	2	—	0	1	1	—
S. Atlantic	8	32	108	1,416	1,841	6	6	15	258	234
Delaware	—	8	28	404	567	—	0	1	5	3
District of Columbia	2	0	7	41	8	—	0	2	3	8
Florida	3	1	5	35	34	3	1	6	51	40
Georgia	—	0	1	3	5	—	1	6	66	43
Maryland†	2	14	65	676	984	3	1	5	57	86
North Carolina	—	0	4	24	42	—	0	8	24	24
South Carolina†	—	0	2	10	19	—	0	2	8	7
Virginia†	1	3	25	214	172	—	1	9	42	22
West Virginia	—	0	44	9	10	—	0	2	2	1
E.S. Central	—	0	3	21	31	—	0	3	19	23
Alabama†	—	0	1	6	2	—	0	2	8	4
Kentucky	—	0	2	7	5	—	0	2	3	8
Mississippi	—	0	0	—	—	—	0	1	3	—
Tennessee†	—	0	2	8	24	—	0	2	5	11
W.S. Central	1	0	3	15	69	—	2	31	55	105
Arkansas	—	0	1	—	4	—	0	1	2	5
Louisiana	—	0	0	—	3	—	0	1	4	3
Oklahoma	—	0	0	—	—	—	0	2	7	9
Texas†	1	0	3	15	62	—	1	29	42	88
Mountain	—	0	3	22	20	1	1	9	53	44
Arizona	—	0	2	4	7	—	0	9	17	10
Colorado	—	0	1	5	—	—	0	2	11	21
Idaho†	—	0	2	4	2	—	0	1	1	—
Montana	—	0	0	—	—	—	0	1	2	—
Nevada†	—	0	1	1	3	—	0	1	1	3
New Mexico†	—	0	1	1	3	—	0	1	4	3
Utah	—	0	1	6	2	1	0	2	17	5
Wyoming	—	0	1	1	3	—	0	0	—	2
Pacific	—	4	17	204	84	2	5	13	190	170
Alaska	—	0	1	2	4	—	0	4	23	5
California	—	4	16	190	54	—	4	10	127	125
Hawaii	N	0	0	N	N	—	0	2	4	15
Oregon†	—	0	2	9	18	—	0	1	9	10
Washington	—	0	3	3	8	2	0	5	27	15
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	1	—	3
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	Meningococcal disease, invasive: All serogroups: Current week	Meningococcal disease, invasive: All serogroups: Previous 52 weeks: Med	Meningococcal disease, invasive: All serogroups: Previous 52 weeks: Max	Meningococcal disease, invasive: All serogroups: Cum 2006	Meningococcal disease, invasive: All serogroups: Cum 2005	Meningococcal disease, invasive: Serogroup unknown: Current week	Meningococcal disease, invasive: Serogroup unknown: Previous 52 weeks: Med	Meningococcal disease, invasive: Serogroup unknown: Previous 52 weeks: Max	Meningococcal disease, invasive: Serogroup unknown: Cum 2006	Meningococcal disease, invasive: Serogroup unknown: Cum 2005	Pertussis: Current week	Pertussis: Previous 52 weeks: Med	Pertussis: Previous 52 weeks: Max	Pertussis: Cum 2006	Pertussis: Cum 2005
United States	5	20	85	840	962	4	13	58	548	587	129	265	2,877	9,945	17,567
New England	—	1	3	35	61	—	0	2	25	22	1	29	83	959	1,057
Connecticut	—	0	2	9	12	—	0	2	2	1	—	1	5	35	52
Maine†	—	0	1	4	2	—	0	1	3	2	—	1	11	63	40
Massachusetts	—	0	2	15	28	—	0	2	15	5	—	19	43	594	805
New Hampshire	—	0	2	5	12	—	0	2	5	12	—	2	36	129	54
Rhode Island	—	0	1	—	2	—	0	0	—	—	—	0	17	45	29
Vermont†	—	0	1	2	5	—	0	0	—	2	1	1	14	93	77
Mid. Atlantic	1	3	14	121	118	1	2	11	90	90	50	34	137	1,412	1,052
New Jersey	—	0	2	11	27	—	0	2	11	27	—	3	13	156	143
New York (Upstate)	—	1	7	31	31	—	0	5	4	11	34	14	123	644	402
New York City	1	0	6	42	18	1	0	6	42	18	—	1	8	64	86
Pennsylvania	—	1	5	37	42	—	0	5	33	34	16	11	26	548	421
E.N. Central	1	3	11	96	120	1	1	6	65	99	23	39	133	1,406	2,986
Illinois	—	0	4	18	27	—	0	4	18	27	—	7	35	230	685
Indiana	—	0	5	19	18	—	0	1	6	8	5	4	75	189	252
Michigan	—	0	3	19	24	—	0	3	8	15	4	7	24	389	246
Ohio	1	1	5	37	32	1	1	4	30	30	14	14	30	459	907
Wisconsin	—	0	2	3	19	—	0	2	3	19	—	4	41	139	896
W.N. Central	—	1	4	45	64	—	0	3	15	28	16	28	552	955	2,908
Iowa	—	0	2	13	15	—	0	1	5	1	—	6	63	212	733
Kansas	—	0	1	1	9	—	0	1	1	9	—	7	28	226	334
Minnesota	—	0	2	11	11	—	0	1	3	4	14	0	485	160	966
Missouri	—	0	2	13	22	—	0	1	2	11	1	7	42	241	361
Nebraska†	—	0	2	5	4	—	0	1	3	3	1	2	9	73	232
North Dakota	—	0	1	1	—	—	0	1	1	—	—	0	25	26	112
South Dakota	—	0	1	1	3	—	0	0	—	—	—	0	4	17	170
S. Atlantic	2	3	14	149	182	2	2	7	61	77	9	20	46	758	1,133
Delaware	—	0	1	4	4	—	0	1	4	4	—	0	1	3	15
District of Columbia	—	0	1	1	5	—	0	1	1	4	2	0	3	6	7
Florida	2	1	6	59	69	2	0	5	21	27	3	4	9	172	165
Georgia	—	0	2	12	14	—	0	2	12	14	—	0	3	15	41
Maryland†	—	0	2	11	19	—	0	1	2	3	1	3	9	97	162
North Carolina	—	0	11	24	28	—	0	3	7	6	1	0	22	155	98
South Carolina†	—	0	2	18	13	—	0	2	8	8	2	3	22	129	322
Virginia†	—	0	4	15	24	—	0	3	6	9	—	2	27	155	284
West Virginia	—	0	2	5	6	—	0	0	—	2	—	0	9	26	39
E.S. Central	—	1	4	31	47	—	1	4	25	36	1	7	16	261	435
Alabama†	—	0	1	5	5	—	0	1	4	3	—	1	7	54	72
Kentucky	—	0	2	7	16	—	0	2	7	16	—	1	5	53	130
Mississippi	—	0	1	3	5	—	0	1	3	5	—	1	4	35	48
Tennessee†	—	0	2	16	21	—	0	2	11	12	1	2	10	119	185
W.S. Central	—	1	23	52	93	—	0	6	23	23	—	16	360	520	1,842
Arkansas	—	0	3	9	12	—	0	2	6	3	—	1	21	47	245
Louisiana	—	0	2	6	28	—	0	1	3	5	—	0	3	11	44
Oklahoma	—	0	4	8	14	—	0	0	—	2	—	0	124	18	1
Texas†	—	1	16	29	39	—	0	4	14	13	—	14	215	444	1,552
Mountain	—	1	5	57	80	—	0	4	27	21	22	61	230	2,099	3,260
Arizona	—	0	3	16	31	—	0	3	16	10	2	9	177	402	819
Colorado	—	0	2	19	17	—	0	1	2	—	5	20	40	650	1,040
Idaho†	—	0	2	3	4	—	0	2	2	3	2	2	8	74	174
Montana	—	0	1	4	—	—	0	1	2	—	—	2	9	96	549
Nevada†	—	0	1	3	12	—	0	0	—	2	—	0	9	39	43
New Mexico†	—	0	1	3	5	—	0	1	1	4	—	2	6	60	152
Utah	—	0	1	5	11	—	0	0	—	2	13	15	39	716	439
Wyoming	—	0	2	4	—	—	0	2	4	—	—	1	8	62	44
Pacific	1	5	29	254	197	—	5	25	217	191	7	42	1,334	1,575	2,894
Alaska	—	0	1	2	3	—	0	1	2	3	—	2	15	61	110
California	—	3	14	156	128	—	3	14	156	128	—	27	1,136	1,099	1,359
Hawaii	—	0	1	7	11	—	0	1	7	6	—	2	4	65	142
Oregon†	—	1	7	60	36	—	1	4	41	36	—	2	8	94	598
Washington	1	0	25	29	19	—	0	11	11	18	7	7	195	256	685
American Samoa	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	1	—	0	0	—	1	—	0	0	—	2
Puerto Rico	—	0	1	4	6	—	0	1	4	6	—	0	1	1	5
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	Rabies, animal					Rocky Mountain spotted fever					Salmonellosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	30	109	173	4,654	4,807	3	37	246	1,599	1,349	640	809	2,291	30,471	33,347
New England	7	11	26	529	574	—	0	2	2	7	6	30	383	1,533	1,776
Connecticut	4	3	14	160	156	—	0	0	—	—	—	0	375	375	392
Maine†	—	2	7	84	50	N	0	0	N	N	—	2	10	91	139
Massachusetts	—	4	17	178	288	—	0	1	1	5	—	18	53	782	941
New Hampshire	1	0	5	39	12	—	0	1	1	1	4	2	24	160	144
Rhode Island	—	0	4	20	20	—	0	2	—	1	—	0	17	73	81
Vermont†	2	1	4	48	48	—	0	0	—	—	2	1	5	52	79
Mid. Atlantic	1	23	59	1,103	779	1	1	6	56	79	59	86	272	3,551	4,069
New Jersey	N	0	0	N	N	—	0	2	7	25	—	14	43	630	805
New York (Upstate)	—	11	22	416	435	—	0	2	4	1	37	22	233	966	965
New York City	1	0	5	20	23	—	0	4	13	6	2	18	36	694	955
Pennsylvania	—	14	42	667	321	1	1	3	32	47	20	29	67	1,261	1,344
E.N. Central	1	1	18	141	163	—	0	6	32	37	72	99	172	3,926	4,597
Illinois	1	0	7	44	47	—	0	1	3	11	—	25	45	854	1,527
Indiana	—	0	2	11	11	—	0	1	5	—	35	15	67	711	479
Michigan	—	0	5	41	35	—	0	1	2	5	3	17	32	749	749
Ohio	—	0	9	45	70	—	0	4	21	19	34	23	56	983	1,058
Wisconsin	N	0	0	N	N	—	0	1	1	2	—	15	27	629	784
W.N. Central	4	5	20	251	281	1	2	15	190	141	35	42	107	1,994	2,040
Iowa	—	0	7	52	—	—	0	1	4	5	—	7	21	335	339
Kansas	—	1	5	61	70	—	0	1	2	5	—	6	16	259	296
Minnesota	—	1	6	36	61	—	0	2	4	2	22	10	60	552	443
Missouri	4	1	8	65	65	1	2	11	159	117	12	14	36	587	634
Nebraska†	—	0	0	—	—	—	0	5	21	7	1	4	9	142	170
North Dakota	—	0	7	16	28	—	0	1	—	—	—	0	46	19	28
South Dakota	—	0	4	21	57	—	0	0	—	5	—	3	7	100	130
S. Atlantic	—	36	118	1,562	1,719	—	16	94	894	674	321	207	450	8,192	9,223
Delaware	—	0	0	—	—	—	0	3	18	7	—	2	9	117	105
District of Columbia	—	0	0	—	—	—	0	1	1	2	2	1	7	50	45
Florida	—	0	99	136	201	—	0	3	15	13	139	95	228	3,449	3,593
Georgia	—	2	9	100	214	—	0	3	28	84	52	27	100	1,243	1,464
Maryland†	—	7	13	254	308	—	1	6	60	60	18	12	29	540	645
North Carolina	—	9	22	397	391	—	15	87	663	356	85	32	130	1,231	1,219
South Carolina†	—	3	10	129	176	—	0	6	23	61	21	19	51	720	1,113
Virginia†	—	10	27	458	383	—	2	13	83	86	4	20	57	751	905
West Virginia	—	1	13	88	46	—	0	2	3	5	—	2	19	91	134
E.S. Central	8	4	16	197	128	—	5	26	273	247	30	54	149	2,197	2,329
Alabama†	8	1	7	69	67	—	1	8	78	64	5	14	71	729	550
Kentucky	—	0	5	23	16	—	0	1	1	3	7	8	22	350	393
Mississippi	—	0	2	4	5	—	0	1	2	13	—	12	47	541	729
Tennessee†	—	2	9	101	40	—	3	20	192	167	18	14	31	577	657
W.S. Central	1	14	34	549	744	1	1	161	101	137	62	83	922	2,904	3,226
Arkansas	1	0	4	26	31	—	0	10	46	98	44	14	45	703	566
Louisiana	—	0	0	—	—	—	0	1	1	6	2	12	35	400	734
Oklahoma	—	1	9	52	67	—	0	154	35	7	16	7	48	382	326
Texas†	—	12	29	471	646	1	0	3	19	26	—	48	839	1,419	1,600
Mountain	8	3	12	156	236	—	0	6	44	25	19	50	84	1,864	1,836
Arizona	6	2	10	119	152	—	0	6	8	12	2	15	67	587	499
Colorado	—	0	1	—	16	—	0	1	2	4	6	12	30	515	472
Idaho†	—	0	12	2	—	—	0	3	13	3	3	3	9	137	114
Montana	—	0	2	13	15	—	0	2	2	1	—	3	16	107	69
Nevada†	—	0	1	1	14	—	0	0	—	—	—	1	17	72	146
New Mexico†	—	0	2	7	9	—	0	2	7	3	—	4	12	179	212
Utah	1	0	1	9	14	—	0	2	6	—	8	5	15	230	255
Wyoming	1	0	2	5	16	—	0	1	6	2	—	1	5	37	69
Pacific	—	4	10	166	183	—	0	1	7	2	36	110	426	4,310	4,251
Alaska	—	0	4	14	1	—	0	0	—	—	1	1	7	62	45
California	—	3	10	135	176	—	0	1	5	—	—	88	292	3,369	3,217
Hawaii	—	0	0	—	—	—	0	0	—	—	—	5	10	181	237
Oregon†	—	0	4	17	6	—	0	1	2	2	1	7	16	324	331
Washington	U	0	0	U	U	N	0	0	N	N	34	7	124	374	421
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	1	U	7
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	1	3	—	30
Puerto Rico	—	1	6	66	55	N	0	0	N	N	11	6	35	189	506
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	Shiga toxin-producing *E. coli* (STEC)†					Shigellosis					Streptococcal disease, invasive, group A				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	54	56	297	2,264	2,419	220	242	1,013	8,895	11,307	42	87	283	3,828	3,635
New England	1	3	59	217	184	—	4	57	205	259	2	4	15	177	235
Connecticut	—	0	58	58	50	—	0	51	51	47	U	0	3	U	82
Maine§	—	0	8	30	28	—	0	2	3	13	—	0	2	15	12
Massachusetts	—	1	9	82	71	—	3	11	128	157	—	2	6	101	107
New Hampshire	1	0	3	22	14	—	0	4	7	12	2	0	9	44	16
Rhode Island	—	0	2	8	5	—	0	6	11	14	—	0	3	5	9
Vermont§	—	0	2	2	16	—	0	2	5	16	—	0	2	12	9
Mid. Atlantic	3	5	107	158	286	5	14	72	589	1,046	5	15	43	699	732
New Jersey	—	0	3	3	62	—	4	26	206	267	—	3	8	122	151
New York (Upstate)	—	0	103	12	110	4	4	60	188	219	4	4	32	251	209
New York City	—	0	4	27	13	1	4	12	128	347	—	1	9	74	143
Pennsylvania	—	0	5	5	101	—	2	5	67	213	1	6	13	252	229
E.N. Central	11	11	52	503	503	5	20	38	703	890	3	14	43	666	757
Illinois	—	1	7	59	120	—	7	16	229	305	—	4	11	144	252
Indiana	4	1	8	68	50	3	2	18	113	121	—	2	11	92	86
Michigan	—	1	7	69	78	—	3	10	119	192	—	3	12	183	179
Ohio	7	3	18	150	126	2	3	11	130	82	3	4	19	205	161
Wisconsin	—	2	39	157	129	—	3	9	112	190	—	1	4	42	79
W.N. Central	10	8	35	335	397	21	34	77	1,225	1,220	10	5	57	285	225
Iowa	—	2	8	108	82	—	2	10	77	68	N	0	0	N	N
Kansas	—	0	3	—	39	—	3	20	103	167	—	1	5	46	35
Minnesota	7	3	27	186	120	17	2	10	122	70	9	0	52	136	86
Missouri	5	2	13	143	82	4	13	69	574	783	1	1	5	61	57
Nebraska§	—	1	8	55	42	—	2	14	102	83	—	0	4	25	18
North Dakota	—	0	15	—	6	—	0	18	63	4	—	0	5	9	9
South Dakota	—	0	5	29	26	—	4	21	184	45	—	0	3	8	20
S. Atlantic	3	7	39	350	322	118	54	122	2,150	1,682	12	22	43	927	725
Delaware	—	0	2	7	8	—	0	2	8	10	—	0	2	10	5
District of Columbia	—	0	1	2	—	1	0	2	14	9	2	0	2	13	8
Florida	1	2	29	75	75	73	26	66	1,064	818	9	6	16	234	188
Georgia	—	1	6	69	44	43	17	41	714	435	—	5	11	176	153
Maryland§	2	1	8	69	66	—	2	10	94	68	1	4	12	169	143
North Carolina	7	1	10	90	44	—	1	21	125	149	—	0	26	138	104
South Carolina§	—	0	2	6	9	1	1	9	69	84	—	1	6	51	30
Virginia§	—	0	8	—	74	—	1	8	60	108	—	2	11	110	72
West Virginia	—	0	2	7	2	—	0	2	2	1	—	0	6	26	22
E.S. Central	5	3	15	171	135	32	13	31	530	1,017	—	3	11	161	141
Alabama§	1	0	5	29	26	17	3	17	176	194	N	0	0	N	N
Kentucky	3	1	8	69	51	3	4	12	171	257	—	0	5	33	28
Mississippi	—	0	1	—	8	—	1	8	61	75	—	0	0	—	—
Tennessee§	—	0	4	24	50	12	3	10	122	491	—	3	9	128	113
W.S. Central	8	1	52	37	84	6	34	596	1,153	2,813	2	7	58	304	254
Arkansas	6	0	3	19	11	1	1	7	81	51	—	0	5	24	15
Louisiana	—	0	1	—	18	—	1	25	90	119	—	0	1	5	5
Oklahoma	2	0	8	18	22	5	3	286	100	524	—	2	14	81	93
Texas§	—	1	44	64	33	—	29	308	882	2,119	2	4	43	194	141
Mountain	1	5	16	233	239	20	22	60	889	641	6	11	78	523	486
Arizona	—	1	8	76	23	4	11	30	468	340	—	6	57	277	206
Colorado	—	1	8	87	62	10	3	18	180	108	5	3	8	112	149
Idaho§	1	1	7	56	32	—	0	4	15	10	—	0	2	8	3
Montana	—	0	1	—	14	—	0	6	12	5	—	0	0	—	—
Nevada§	—	0	3	10	18	—	0	8	30	44	—	0	2	—	8
New Mexico§	—	0	1	4	22	—	2	10	114	96	—	1	7	63	68
Utah	5	1	13	103	61	5	1	6	62	33	1	1	7	60	49
Wyoming	—	0	3	17	7	1	0	3	8	5	—	0	1	3	3
Pacific	12	7	55	260	269	13	40	148	1,451	1,739	2	2	9	86	80
Alaska	—	0	1	—	9	—	0	2	9	11	—	0	0	—	—
California	—	4	18	161	103	—	32	104	1,189	1,488	—	0	0	—	—
Hawaii	—	0	2	12	10	—	1	4	33	28	2	2	9	86	80
Oregon§	3	2	47	99	72	1	2	31	110	112	N	0	0	N	N
Washington	12	1	32	87	75	12	2	43	110	100	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	7	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	3	—	16	—	0	0	—	—
Puerto Rico	—	0	0	—	2	1	0	2	12	5	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-0157; and Shiga toxin positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease Drug resistant, all ages					Syphilis, primary and secondary					Varicella (chickenpox)				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005
United States	84	50	334	1,976	2,040	79	172	334	6,711	6,463	442	802	3,204	31,532	21,295
New England	—	1	24	30	176	2	4	17	157	159	16	39	144	1,147	4,043
Connecticut	U	0	7	U	74	1	0	11	34	34	U	0	58	U	1,196
Maine†	—	0	2	8	N	—	0	2	7	1	—	5	20	151	240
Massachusetts	—	0	6	—	76	1	2	6	97	98	—	0	54	94	1,816
New Hampshire	—	0	0	—	—	—	0	2	10	13	10	7	47	376	231
Rhode Island	—	0	11	10	17	—	0	6	7	12	—	0	0	—	—
Vermont†	—	0	2	12	9	—	0	1	2	1	6	12	50	526	560
Mid. Atlantic	1	3	15	125	169	13	21	35	855	801	84	103	183	3,659	3,605
New Jersey	N	0	0	N	N	—	3	7	128	111	—	0	0	—	—
New York (Upstate)	—	1	10	44	65	5	2	14	117	62	—	0	0	—	—
New York City	U	0	0	U	U	4	10	23	410	481	—	0	0	—	—
Pennsylvania	1	2	9	81	104	4	5	9	200	147	84	103	183	3,659	3,605
E.N. Central	7	11	41	442	510	8	17	38	678	700	121	237	587	11,255	4,425
Illinois	—	0	3	15	26	1	8	23	313	393	—	2	7	68	78
Indiana	1	2	21	117	160	2	1	4	68	51	—	0	475	475	251
Michigan	—	0	4	17	33	1	2	19	90	63	33	102	174	3,266	2,637
Ohio	6	6	32	293	291	4	4	8	159	167	88	93	420	6,816	1,118
Wisconsin	N	0	0	N	N	—	1	4	48	26	—	12	52	630	341
W.N. Central	62	1	191	96	34	1	5	10	194	195	7	23	84	1,108	350
Iowa	N	0	0	N	N	—	0	2	11	8	N	0	0	N	N
Kansas	N	0	0	N	N	—	0	2	16	15	—	0	8	20	—
Minnesota	60	0	191	60	—	—	0	3	21	57	—	0	0	—	—
Missouri	2	1	3	35	27	—	3	8	130	110	7	19	82	1,006	242
Nebraska†	—	0	0	—	2	—	0	1	3	4	—	0	0	—	—
North Dakota	—	0	1	—	2	—	0	1	1	—	—	0	25	44	20
South Dakota	—	0	1	1	3	1	0	3	12	1	—	1	12	38	88
S. Atlantic	13	26	53	1,035	835	25	42	186	1,619	1,584	22	90	860	3,328	1,646
Delaware	—	0	2	—	1	—	0	2	16	9	—	1	5	52	25
District of Columbia	1	0	3	23	13	5	2	9	101	86	2	0	5	30	28
Florida	10	14	36	574	460	10	15	29	575	537	—	0	0	—	—
Georgia	2	7	29	343	265	1	7	147	277	332	—	0	0	—	—
Maryland†	—	0	0	—	—	1	5	19	229	247	—	0	0	—	—
North Carolina	N	0	0	N	N	5	5	17	229	205	—	0	0	—	—
South Carolina†	—	0	0	—	—	1	1	7	54	58	10	15	53	809	439
Virginia†	N	0	0	N	N	1	3	12	133	107	—	30	512	1,287	350
West Virginia	—	1	14	95	96	1	0	1	5	3	10	26	70	1,150	804
E.S. Central	—	3	13	152	143	7	13	25	547	356	—	1	70	91	95
Alabama†	N	0	0	N	N	—	4	19	238	115	—	1	70	90	95
Kentucky	—	0	5	29	26	1	1	8	56	36	N	0	0	N	N
Mississippi	—	0	0	—	1	—	0	6	47	39	—	0	1	1	—
Tennessee†	—	3	13	123	116	6	5	13	206	166	N	0	0	N	N
W.S. Central	—	0	4	17	99	12	27	43	1,153	953	134	183	1,757	8,838	5,089
Arkansas	—	0	3	12	12	1	1	5	60	40	—	7	110	590	—
Louisiana	—	0	4	5	87	10	4	17	190	199	—	0	8	44	110
Oklahoma	N	0	0	N	N	1	1	6	57	29	—	0	0	—	—
Texas†	N	0	0	N	N	—	21	36	846	685	134	170	1,647	8,204	4,979
Mountain	1	1	8	79	74	10	7	25	322	332	58	54	138	2,106	2,042
Arizona	N	0	0	N	N	7	3	16	144	132	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	3	32	36	35	33	76	1,152	1,408
Idaho†	N	0	0	N	N	—	0	1	2	20	—	0	0	—	—
Montana	—	0	1	—	—	—	0	1	1	5	—	0	2	2	—
Nevada†	—	0	3	4	29	3	1	12	83	91	—	0	2	4	2
New Mexico†	—	0	1	1	—	—	1	5	52	40	—	3	34	307	172
Utah	—	0	8	34	23	—	0	1	8	8	23	10	55	608	409
Wyoming	1	1	4	40	22	—	0	0	—	—	—	0	8	33	51
Pacific	—	0	0	—	—	1	33	49	1,186	1,383	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	4	9	6	—	0	0	—	—
California	N	0	0	N	N	—	28	39	1,007	1,235	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	15	9	N	0	0	N	N
Oregon†	N	0	0	N	N	—	0	6	13	26	N	0	0	N	N
Washington	N	0	0	N	N	1	3	10	142	107	N	0	0	N	N
American Samoa	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	3	—	4	12	—	389
Puerto Rico	N	0	0	N	N	—	2	10	86	164	3	8	47	284	554
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending October 7, 2006, and October 8, 2005 (40th Week)*

Reporting area	West Nile virus disease†									
	Neuroinvasive					Non-neuroinvasive				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	—	1	161	1,119	1,246	—	1	344	1,895	1,653
New England	—	0	3	8	9	—	0	2	3	4
Connecticut	—	0	2	6	4	—	0	1	2	2
Maine§	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	2	4	—	0	1	1	2
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	0	—	1	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	6	16	47	—	0	3	6	22
New Jersey	—	0	2	2	3	—	0	1	2	3
New York (Upstate)	—	0	1	—	19	—	0	1	—	5
New York City	—	0	4	7	11	—	0	2	3	3
Pennsylvania	—	0	2	7	14	—	0	1	1	11
E.N. Central	—	0	35	188	255	—	0	18	77	153
Illinois	—	0	21	111	136	—	0	16	55	114
Indiana	—	0	4	11	10	—	0	2	5	11
Michigan	—	0	7	29	54	—	0	1	2	8
Ohio	—	0	11	27	45	—	0	3	7	14
Wisconsin	—	0	2	10	10	—	0	2	8	6
W.N. Central	—	0	31	191	161	—	0	73	374	461
Iowa	—	0	2	17	13	—	0	4	12	23
Kansas	—	0	3	14	13	—	0	3	10	N
Minnesota	—	0	6	29	18	—	0	7	34	27
Missouri	—	0	12	41	17	—	0	3	9	13
Nebraska§	—	0	7	33	53	—	0	24	123	131
North Dakota	—	0	5	20	12	—	0	27	115	74
South Dakota	—	0	7	37	35	—	0	22	71	193
S. Atlantic	—	0	3	8	29	—	0	3	6	26
Delaware	—	0	0	—	1	—	0	1	—	—
District of Columbia	—	0	0	—	3	—	0	1	1	1
Florida	—	0	2	3	8	—	0	0	—	11
Georgia	—	0	1	2	7	—	0	2	4	10
Maryland§	—	0	1	2	4	—	0	1	1	1
North Carolina	—	0	0	—	2	—	0	0	—	2
South Carolina§	—	0	1	—	4	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	0	—	1
West Virginia	—	0	1	1	—	N	0	0	N	N
E.S. Central	—	0	12	86	62	—	0	15	81	36
Alabama§	—	0	1	4	6	—	0	2	—	2
Kentucky	—	0	1	3	4	—	0	1	1	—
Mississippi	—	0	9	72	38	—	0	15	79	31
Tennessee§	—	0	3	7	14	—	0	1	1	3
W.S. Central	—	1	55	283	249	—	0	25	147	145
Arkansas	—	0	4	21	12	—	0	2	5	15
Louisiana	—	0	14	66	106	—	0	8	49	53
Oklahoma	—	0	6	21	16	—	0	3	12	11
Texas§	—	0	35	175	115	—	0	14	81	66
Mountain	—	0	59	270	134	—	0	196	993	228
Arizona	—	0	4	15	44	—	0	5	14	49
Colorado	—	0	10	54	20	—	0	43	219	85
Idaho§	—	0	29	94	3	—	0	128	542	10
Montana	—	0	3	10	8	—	0	7	19	17
Nevada§	—	0	9	34	14	—	0	13	73	17
New Mexico§	—	0	1	1	19	—	0	1	2	13
Utah	—	0	8	48	21	—	0	17	88	31
Wyoming	—	0	7	14	5	—	0	7	36	6
Pacific	—	0	15	69	300	—	0	45	208	578
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	15	65	299	—	0	33	164	572
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon§	—	0	2	4	1	—	0	12	42	6
Washington	—	0	0	—	—	—	0	2	2	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending October 7, 2006 (40th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	516	358	115	25	14	4	41
Boston, MA	124	79	27	7	8	3	9
Bridgeport, CT	35	21	12	2	—	—	1
Cambridge, MA	7	5	2	—	—	—	—
Fall River, MA	27	22	4	—	1	—	1
Hartford, CT	48	36	11	—	1	—	6
Lowell, MA	25	18	5	1	1	—	1
Lynn, MA	13	10	3	—	—	—	2
New Bedford, MA	19	14	5	—	—	—	—
New Haven, CT	44	29	11	3	—	1	6
Providence, RI	60	43	12	4	1	—	7
Somerville, MA	5	3	2	—	—	—	—
Springfield, MA	30	21	5	4	—	—	—
Waterbury, CT	34	24	6	3	1	—	4
Worcester, MA	45	33	10	1	1	—	4
Mid. Atlantic	1,995	1,362	436	129	36	31	108
Albany, NY	40	26	10	1	3	—	4
Allentown, PA	25	17	6	1	—	1	1
Buffalo, NY	62	40	17	3	2	—	6
Camden, NJ	19	8	7	3	—	1	—
Elizabeth, NJ	10	8	2	—	—	—	—
Erie, PA	38	31	5	1	—	1	3
Jersey City, NJ	19	12	7	—	—	—	2
New York City, NY	1,024	705	219	69	16	14	41
Newark, NJ	49	19	15	8	2	5	1
Paterson, NJ	26	15	8	2	—	1	1
Philadelphia, PA	321	201	89	21	8	2	19
Pittsburgh, PA§	24	18	4	1	—	1	—
Reading, PA	25	18	3	2	1	1	2
Rochester, NY	119	85	25	6	1	2	10
Schenectady, NY	21	16	1	4	—	—	2
Scranton, PA	25	23	2	—	—	—	2
Syracuse, NY	85	71	7	3	2	2	8
Trenton, NJ	21	14	6	1	—	—	—
Utica, NY	14	12	1	1	—	—	2
Yonkers, NY	28	23	2	2	1	—	4
E.N. Central	1,967	1,314	436	134	33	50	136
Akron, OH	48	28	13	2	1	4	4
Canton, OH	25	19	6	—	—	—	3
Chicago, IL	330	199	72	34	13	12	25
Cincinnati, OH	101	64	27	5	1	4	10
Cleveland, OH	232	169	47	13	—	3	7
Columbus, OH	196	144	33	11	2	6	22
Dayton, OH	119	84	30	3	1	1	8
Detroit, MI	152	75	53	19	2	3	11
Evansville, IN	49	38	7	3	1	—	2
Fort Wayne, IN	36	20	12	3	1	—	1
Gary, IN	11	4	4	2	1	—	—
Grand Rapids, MI	45	29	11	2	—	3	5
Indianapolis, IN	187	124	47	10	2	4	8
Lansing, MI	44	34	9	1	—	—	2
Milwaukee, WI	95	71	13	6	2	3	3
Peoria, IL	36	24	9	1	1	1	3
Rockford, IL	54	41	8	2	2	1	4
South Bend, IN	52	31	11	5	1	4	3
Toledo, OH	104	75	16	10	2	1	11
Youngstown, OH	51	41	8	2	—	—	4
W.N. Central	566	362	127	32	19	26	34
Des Moines, IA	53	36	16	1	—	—	3
Duluth, MN	24	19	5	—	—	—	2
Kansas City, KS	26	18	5	1	2	—	1
Kansas City, MO	107	70	24	5	2	6	6
Lincoln, NE	34	21	10	3	—	—	2
Minneapolis, MN	53	34	7	7	3	2	4
Omaha, NE	72	51	11	4	2	4	5
St. Louis, MO	78	35	24	7	5	7	4
St. Paul, MN	59	41	12	1	3	2	3
Wichita, KS	60	37	13	3	2	5	4
S. Atlantic	988	612	245	75	31	25	65
Atlanta, GA	63	40	18	3	2	—	2
Baltimore, MD	116	64	32	10	7	3	12
Charlotte, NC	119	73	23	12	7	4	14
Jacksonville, FL	114	64	30	11	6	3	6
Miami, FL	97	69	21	4	—	3	11
Norfolk, VA	51	29	11	6	2	3	2
Richmond, VA	42	25	14	3	—	—	3
Savannah, GA	50	31	13	5	—	1	2
St. Petersburg, FL	47	32	8	3	1	3	5
Tampa, FL	172	110	42	14	4	2	5
Washington, D.C.	100	62	30	3	2	3	1
Wilmington, DE	17	13	3	1	—	—	2
E.S. Central	874	542	235	62	18	17	63
Birmingham, AL	173	106	47	13	2	5	14
Chattanooga, TN	58	39	11	5	1	2	3
Knoxville, TN	101	70	24	6	—	1	5
Lexington, KY	94	65	22	3	2	2	6
Memphis, TN	137	82	33	14	3	5	13
Mobile, AL	91	59	18	11	3	—	6
Montgomery, AL	65	37	24	3	1	—	7
Nashville, TN	155	84	56	7	6	2	9
W.S. Central	1,239	775	307	93	29	35	47
Austin, TX	77	46	22	6	2	1	1
Baton Rouge, LA	64	35	21	6	2	—	1
Corpus Christi, TX	48	35	10	3	—	—	2
Dallas, TX	181	103	43	14	3	18	9
El Paso, TX	74	53	13	5	2	1	3
Fort Worth, TX	94	63	21	3	2	5	2
Houston, TX	344	199	99	29	11	6	11
Little Rock, AR	71	41	20	4	3	3	—
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	141	90	38	11	1	1	8
Shreveport, LA	55	41	9	3	2	—	8
Tulsa, OK	90	69	11	9	1	—	2
Mountain	966	611	233	68	27	27	60
Albuquerque, NM	133	86	38	7	2	—	7
Boise, ID	63	41	12	5	2	3	4
Colorado Springs, CO	51	40	6	2	—	3	2
Denver, CO	81	48	27	3	2	1	4
Las Vegas, NV	244	164	57	16	4	3	17
Ogden, UT	24	16	4	3	1	—	1
Phoenix, AZ	189	92	54	26	10	7	14
Pueblo, CO	25	20	4	1	—	—	2
Salt Like City, UT	156	104	31	5	6	10	9
Tucson, AZ	U	U	U	U	U	U	U
Pacific	1,602	1,096	338	93	42	33	117
Berkeley, CA	14	11	2	—	—	1	3
Fresno, CA	152	97	35	11	4	5	5
Glendale, CA	8	6	2	—	—	—	3
Honolulu, HI	66	52	8	3	2	1	5
Long Beach, CA	52	40	6	3	2	1	8
Los Angeles, CA	211	120	55	19	11	6	16
Pasadena, CA	27	18	8	1	—	—	1
Portland, OR	130	90	29	7	3	1	5
Sacramento, CA	236	165	51	9	6	5	15
San Diego, CA	170	118	34	13	2	3	15
San Francisco, CA	104	79	21	3	—	1	17
San Jose, CA	161	115	28	11	3	4	11
Santa Cruz, CA	25	17	4	1	2	1	1
Seattle, WA	89	54	21	7	5	2	5
Spokane, WA	65	47	13	2	1	2	4
Tacoma, WA	92	67	21	3	1	—	3
Total	10,713**	7,032	2,472	711	249	248	671

U: Unavailable. —:No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

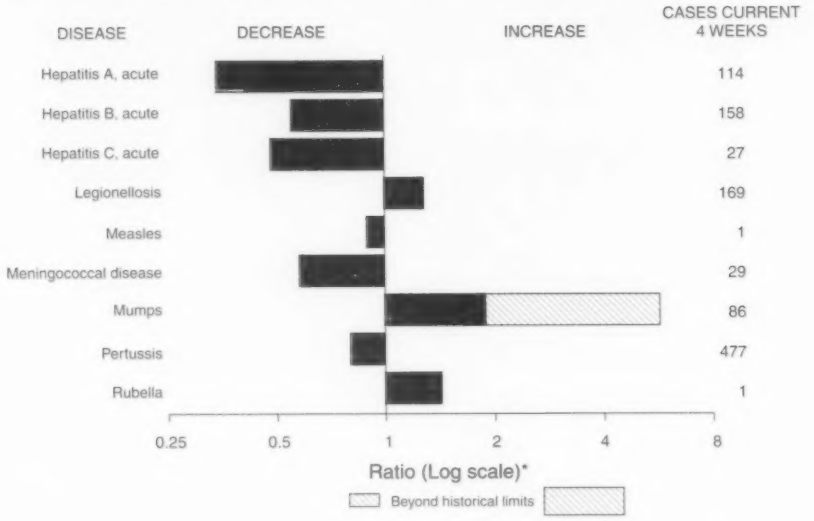
** Total includes unknown ages.

TABLE IV. Provisional cases of selected notifiable diseases,* United States, quarter ending September 30, 2006 (39th Week)

Reporting area	Tuberculosis				
	Current quarter	Previous 4 quarters Min	Previous 4 quarters Max	Cum 2006	Cum 2005
United States	3,090	2,384	3,589	8,100	9,661
New England	90	60	167	224	278
Connecticut	22	11	35	52	60
Maine	3	2	4	8	13
Massachusetts	53	31	113	142	161
New Hampshire	5	0	5	9	4
Rhode Island	7	0	12	10	35
Vermont	—	0	3	3	5
Mid. Atlantic	505	472	605	1,501	1,491
New Jersey	137	101	137	370	361
New York (Upstate)	61	50	110	172	192
New York City	250	232	269	719	715
Pennsylvania	57	57	102	240	223
E.N. Central	284	219	371	815	948
Illinois	120	91	158	369	453
Indiana	39	24	40	91	106
Michigan	44	30	93	129	153
Ohio	68	54	83	180	177
Wisconsin	13	13	19	46	59
W.N. Central	131	95	142	331	348
Iowa	5	4	19	18	36
Kansas	28	15	31	80	46
Minnesota	62	34	62	150	143
Missouri	30	15	38	68	70
Nebraska	6	1	6	10	40
North Dakota	—	0	4	—	2
South Dakota	—	0	5	5	11
S. Atlantic	608	369	839	1,549	2,041
Delaware	9	3	9	18	19
District of Columbia	18	10	18	48	42
Florida	247	177	354	646	740
Georgia	64	8	131	203	418
Maryland	48	26	79	153	212
North Carolina	100	57	126	231	203
South Carolina	33	6	47	47	164
Virginia	83	49	131	188	224
West Virginia	6	4	7	15	19
E.S. Central	147	147	211	473	531
Alabama	44	44	52	145	168
Kentucky	21	12	43	59	81
Mississippi	23	23	36	82	67
Tennessee	59	59	84	187	215
W.S. Central	410	136	462	1,008	1,338
Arkansas	26	19	37	82	79
Louisiana	—	0	0	—	—
Oklahoma	27	23	55	105	102
Texas	357	76	388	821	1,157
Mountain	139	65	193	296	402
Arizona	90	25	115	176	166
Colorado	3	0	34	17	67
Idaho	—	0	7	—	16
Montana	—	0	2	—	8
Nevada	21	9	24	45	88
New Mexico	13	7	13	31	32
Utah	11	4	11	25	25
Wyoming	1	0	1	2	—
Pacific	776	528	776	1,903	2,284
Alaska	12	11	19	42	46
California	652	446	652	1,578	1,891
Hawaii	43	18	43	92	87
Oregon	—	0	28	—	75
Washington	69	45	77	191	185
American Samoa	U	0	2	U	U
C.N.M.I.	—	0	0	—	U
Guam	—	0	8	—	55
Puerto Rico	62	0	62	79	76
U.S. Virgin Islands	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable.
Cum: Cumulative year-to-date counts. Min: Minimum. Max: Maximum.
* AIDS and HIV/AIDS data are not updated for this quarter because of upgrading of the national HIV/AIDS surveillance data management system.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals October 7, 2006, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

Notifiable Disease Morbidity and 122 Cities Mortality Data Team

Patsy A. Hall

Deborah A. Adams
Willie J. Anderson
Lenee Blanton
Rosaline Dhara
Vernitta Love
Pearl C. Sharp

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format. To receive an electronic copy each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's Internet server at *http://www.cdc.gov/mmwr* or from CDC's file transfer protocol server at *ftp://ftp.cdc.gov/pub/publications/mmwr*. Paper copy subscriptions are available through the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone 202-512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of busi Friday; compiled data on a national basis are officially released to the public on the following Friday. Data are compiled in the National Center for Public Informatics, Division of Integrated Surveillance Systems and Services. Address all inquiries about the *MMWR* Series, including material to be consid publication, to Editor, *MMWR* Series, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333 or to *www.mmwrq@cdc.gov*.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreci

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human S

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organiza their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses l *MMWR* were current as of the date of publication.

☆U.S. Government Printing Office: 2006-523-056/40079 Region IV ISSN: 0149-2195

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)
ATLANTA, GA 30333

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE $300
RETURN SERVICE REQUESTED

93036 0001
PROQUEST INFORMATION & LEARNING
PERIODICALS ACQUISITION
PO BOX 1346
ANN ARBOR, MI 48106-1346

FIRST-CLASS MAIL
POSTAGE & FEES PAID
PHS/CDC
Permit No. G-284